The Evolution of the Oregon Health Plan

First Interim Report

Prepared by:

Margo L. Rosenbach, Ph.D.
A. James Lee, Ph.D.
Constance Hwang, B.A.

Health Economics Research, Inc.

and

Steven A. Garfinkel, Ph.D.

Research Triangle Institute

Nancy Swigonski, M.D.

Indiana University

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Executive Summary

The Oregon Health Plan (OHP) is an innovative effort by the State of Oregon to extend health insurance coverage to uninsured State residents below poverty. The costs of expanded insurance coverage are financed through the use of a prioritized list of health care services (to determine the benefit package), increased enrollment in capitated managed care organizations (MCOs)[1], as well as revenues generated by a cigarette tax earmarked for OHP.

The Oregon Health Plan was implemented in February 1994 under a Section 1115 waiver from the Health Care Financing Administration (HCFA). As a Section 1115 demonstration program, the OHP is being evaluated through a HCFA-funded evaluation contract. The evaluation addresses both the implementation process and program impacts, using qualitative and quantitative approaches.

This report is the First Interim Report produced by the evaluation. This report discusses how the Oregon Health Plan program has evolved since it was implemented in February 1994. The report is based on three site visits conducted in November 1994, October 1995, and June 1996, as well as analysis of secondary data maintained by the State. Data sources include the monthly enrollment and disenrollment reports, audited financial

[1] The *managed care expansion* builds on a previous 1915(b) waiver program in which Aid to Families with Dependent Children (AFDC) Medicaid beneficiaries were mandatorily enrolled in managed care settings in fifteen counties and voluntarily enrolled in two counties. Under OHP, however, enrollment in fully capitated health plans (FCHPs) is mandatory in most counties (and in most ZIP codes in those counties).

statements from managed care plans, and other administrative reports. Additional phone follow-up occurred on an as-needed basis.

Legislative Origins

One of the key components that paved the way for implementation of the demonstration was the "up-front" legislative process that took place before the waiver application was prepared. Senate Bill 27 was enacted in 1989 and provided the foundation for the Oregon Health Plan. The legislation contained four basic premises:

- The State would take responsibility for insuring legal State residents with incomes below the Federal poverty level, without regard to categorical criteria.
- The State would develop a prioritized list of health services (ranked according to clinical effectiveness and social value) and the scope of benefits would be tied explicitly to the budget process. Services above the cut-off line would be funded; those below the line would not be covered.
- The State would set reimbursement levels sufficient to cover costs, to eliminate cost-shifting and to increase provider participation.
- The State would make an overt commitment to managed care where feasible.

The State of Oregon submitted its Section 1115 waiver application to HCFA in August 1991. The waiver application was approved in March 1993 after several revisions of the prioritized list of health services to comply with the Federal Americans with Disabilities Act (ADA). Following a ten-month start-up period, the program began enrolling

individuals on February 1, 1994. Phase I of the demonstration included all traditional Medicaid eligibles other than the aged, blind/disabled, and children in foster care, as well as those who were newly eligible under the poverty-level expansion. Phase II, which began January 1, 1995 brought most of the remaining traditional Medicaid eligibility groups into OHP.

Changes in Program Organization

One of the challenges faced by a State Medicaid agency in implementing a Medicaid managed care program is to transform its organization from a fee-for-service indemnity insurer to managing contracts with capitated managed care organizations (MCOs). The Office of Medical Assistance Programs (OMAP) administers Oregon's Medicaid program, and is responsible for the design and implementation of the demonstration.

Pre-Demonstration Organization. Initial responsibility for planning the demonstration was located within OMAP's Prioritized Health Care Unit, a dedicated staff of five professionals, which had been operational since 1989. Upon approval of the Section 1115 waiver application in March 1993, OMAP created a Managed Health Care Unit to provide a focal point for managed care activities within the agency and to assume the lead role in the demonstration project.

Consolidation and Streamlining. Following the Phase I implementation, OMAP began a series of organizational changes, characterized mainly by streamlining and consolidation of the fee-for-service operations. For example, no longer was it necessary to

maintain dual quality assurance units, one for fee-for-service and another for managed care. Similarly, a consolidated Program and Policy Unit was established to assume responsibility for both fee-for-service and managed care policies and procedures, acknowledging that managed care is now OMAP's primary delivery system.

OMAP's process of streamlining runs contrary to the original prediction of a permanently expanded staff. After the initial staff expansion prior to the Phase I implementation in February 1994, OMAP has since conducted a gradual downsizing of its staff. In addition to addressing budget constraints, the decrease in staff is viewed by OMAP as an indication of a maturing program whereby much of the administrative support previously necessary for implementation has now become superfluous in an operational program. Two areas of steady growth, however, have been in the hiring of Prepaid Health Plan (PHP) Coordinators to facilitate OMAP's interaction with PHPs and Primary Care Case Managers (PCCMs), as well as Site Review Coordinators to expand OMAP's capacity for monitoring PHPs.[2]

Creation of New Administrative Entities. The State has faced challenges in coordinating the multi-faceted Oregon Health Plan and insuring its continued survival within the changing political context. Besides the Medicaid demonstration, the Oregon Health Plan involves private sector initiatives, including small market insurance reform, a high risk pool,

[2] Prepaid health plans included both fully-capitated health plans (FCHPs) such as HMOs, as well as physician care organizations (PCOs) which were partially capitated. By November 1996, however, there no longer were any PCOs in OHP; they either had converted to FCHPs, or dropped out altogether.

and a voluntary tax credit program. State officials felt that these efforts were not being coordinated effectively with each other, and they were concerned that no one person was responsible for overseeing all of the public and private sector initiatives for the working poor. Thus, the Office of the Health Plan Administrator (OHPA) was created to coordinate OHP's various public and private sector components.[3]

Another important organizational development was the creation of the Federal Policy Coordinator position within the Governor's office (September 1995). At the time, Congress was actively debating the future of the Medicaid program, and the fate of Section 1115 demonstration programs was in jeopardy. The Federal Policy Coordinator position was created to represent the State's concerns during the debate.

Eligibility and Enrollment

OHP expanded Medicaid eligibility to legal State residents below the poverty level, without regard to categorical eligibility criteria. One of the key challenges during the first year of the Oregon Health Plan was in processing applications for the newly-eligible population. Response to the program exceeded all expectations and required program adaptations to accommodate the demand.

Program Modifications. In response to budget pressures, OMAP initiated discussions with HCFA concerning the modification of eligibility criteria to exclude

[3] In December 1995, the OHPA merged with the Department of Human Resources (DHR) Office of Health Policy. In 1997, the office was renamed the Office for OHP Health Policy and Research. The name change occurred due to confusion over the role of OMAP versus OHPA vis-a-vis the administration of OHP.

certain persons who were believed to be less vulnerable. With HCFA's approval, OMAP instituted three changes to the original Phase I eligibility rules beginning on October 1, 1995:

- Income is measured as the average of the most recent three months' income instead of the previous month's income alone. The Medicaid program traditionally used only the income for the preceding month, because beneficiaries were recertified monthly. However, since the expansion population is recertified every six months, persons who qualified on the basis of one month of unusually low income could remain eligible for months during which they might not otherwise have been eligible. The three-month average is designed to minimize this possibility.[4]

- Persons with $5,000 or more in liquid assets, excluding house and car, are now ineligible for OHP.

- Full-time college students are now ineligible for OHP unless they are pregnant or in a JOBS program.[5]

Although these changes introduced eligibility restrictions that were not originally intended, the fundamental 100 percent FPL criterion is still in place.

Effective December 1, 1995, OMAP began charging premiums to expansion eligibles, including single adults, childless couples, and new families. For a single-person family, premiums ranged from $6.00 per month below 50 percent of FPL to $20.00 per month for those 86 to 100 percent of FPL. For a family of four, the monthly payment ranged from $7.50 (below 50 percent of FPL) to $28.00 (86 to 100 percent of FPL). The State

[4] In part, this change was brought about in response to a highly-publicized case in which a millionaire qualified for the Oregon Health Plan and then held a press conference criticizing the program.

[5] However, beginning January 1, 1998, eligibility for some full-time college students will be reinstated.

maintains continuous eligibility for the six-month certification period if enrollees are not current in their premium payments; however, beneficiaries are denied recertification if they are not up-to-date when they reapply unless they have a "hardship exception."[6]

Another recent modification to the eligibility process was the requirement that OHP eligibles choose a health plan before they are actually enrolled in OHP. Previously, they were enrolled in OHP on a fee-for-service basis until they had chosen a health plan; however, to minimize the fee-for-service liability, as well as to maximize managed care enrollment, OHP eligibles are now required to choose a health plan before they are enrolled.

Eligibility Trends. The Phase I OHP population swelled from 197,800 in March 1994 to 329,000 in October 1995 (a 66 percent increase), and then gradually declined to just over 268,000 in August 1997 (an 18 percent reduction). During this timeframe, the number of current eligibles actually has fallen, and thus, the entire growth in OHP enrollment is attributable to the expansion population. OMAP staff attribute the decrease in current eligibles to an extremely aggressive JOBS program for the AFDC population, which resulted in reduced categorical eligibility, and the shift of some categorically eligible persons to expansion eligibility. This trend may reflect the joint effect of welfare reform and health care reform in decreasing the AFDC rolls in the State.

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[6] Hardship exceptions were required by HCFA as a way to provide continuing coverage to persons who are unable to pay the premium. To qualify for a premium waiver, beneficiaries must submit either a written application to the State or explain their circumstances to an AFS worker. The criteria under which a beneficiary may be excluded from paying a monthly premium include: zero income level, victim of domestic violence, victim of crime causing loss of money or income, victim of natural disaster, death of a household member, loss of housing, or homelessness.

The OHP expansion population -- comprised of single adults, childless couples, and new families -- grew from 10,700 eligibles in March 1994 (the second month of the program) to nearly 100,000 by December 1994. This growth exceeded all projections for initial program enrollment. The number of expansion eligibles continued to grow, peaking at 134,000 in October 1995, when new eligibility criteria were introduced, including an assets test, income averaging over three months, and elimination of full-time students. Further reductions in the number of expansion eligibles took place following May 1996, when up-to-date premiums were required as a precondition to recertification.

Managed Care Enrollment. The rate of enrollment in a fully or partially capitated health plan grew steadily from 75 percent in July 1994 to 82 percent in December 1996, and leveled off at this rate through July 1997. Enrollment with a primary care case manager (PCCM) accounted for a small additional share (2.4 percent in July 1997), indicating that few formal exemptions from prepaid health plan enrollment have been granted. The share remaining in fee-for-service has declined over time, from 24 percent in July 1994 to 16 percent in July 1997, due in part to more aggressive efforts to enroll eligibles in managed care coupled with greater managed care capacity.

Health Plan Disenrollment Rates. Several health plans are experiencing more rapid disenrollment than they had expected. The disenrollment rate due to loss of eligibility has fluctuated between a low of 4.1 percent in July 1994 (before the six-month recertifications began) to a high of 8.8 percent in December 1995 when the State began charging premiums to expansion eligibles. The disenrollment rate, for all reasons combined, has reached over

10 percent in many months, indicating that one in every ten managed care enrollee left their health plan in a given month. Health plans are concerned about the administrative expenses they incur from turnover, and the potential for adverse selection. The health plans attribute this higher-than-expected disenrollment to: (1) the instability generated by monthly recertification of categorically-eligible beneficiaries; and (2) the failure of large numbers of newly-eligible beneficiaries to reapply at the scheduled six-month recertification. They believe that some beneficiaries fail to apply for recertification if they are not ill at the time they are scheduled for recertification and then reapply when they next need health care. Although the health plans believe that this rate is high, OMAP staff believe that it is consistent with turnover in AFDC eligibility.

Managed Care Plan Contracts and Financial Status

Managed Care Capacity Prior to OHP. Oregon's Medicaid managed care experience dates back to 1985 under a 1915(b) freedom of choice waiver. At the time of the Section 1115 waiver application (August 1991), the State contracted with 16 health plans, which served 65,320 Medicaid eligibles, representing about 55 percent of the AFDC population. The State and health plans credit their extensive experience with managed care for the smooth transition to OHP. A core group of health plans already had experience with the Medicaid population and existing reimbursement arrangements with hospitals and physicians.

The State used the interval between the Phase I waiver submission and waiver approval to build the delivery system. The State issued an RFA for prepaid health plans in November 1991, requesting letters of intent from prospective health plans interested in participating in the Oregon Health Plan. The State left the RFA open until the waiver was approved (March 1993). State officials were struck by the profound changes in capacity brought about by the RFA, and provider interest in gaining a share of the Medicaid market. Moreover, new health plans were created just for OHP. The State undertook a review of each plan's policies and procedures, with the aid of a multidisciplinary review panel comprised of experts in public health, managed care, health policy, and medicine. During this interval, the State provided a considerable amount of technical assistance to plans.

Diffusion of Medicaid Managed Care. OHP continues to give impetus to the development of managed care throughout the State. Through a combination of service area expansions, new plan developments, and partially- to fully-capitated health plan (FCHP) conversions, just two counties (Gilliam and Tillamook) remain without an FCHP. OMAP continues to require mandatory PCCM enrollment in Gilliam and Tillamook counties, but is no longer attempting to promote capitated managed care plans in the two counties due to a lack of capacity.

Market Shares of Prepaid Health Plans. In December 1994, nearing the end of the first year of OHP, 220,000 OHP eligibles were enrolled in the 20 prepaid health plans. HMO Oregon, the Blue Cross & Blue Shield HMO, had 37 percent of OHP enrollment. The next two largest health plans, CareOregon and Kaiser, had 9 percent each. Another two

plans -- ODS Health Plan and SelectCare -- enrolled 5 percent or more. These five largest plans accounted for two-thirds of OHP enrollees in managed care plans. With a cumulative enrollment of just 9 percent, the eight smallest plans enrolled less than 2 percent each. Four of these plans enrolled less than 1 percent.

The level of concentration increased over time, with the top five plans accounting for slightly over 70 percent of the OHP market in December 1995, and nearly 73 percent in July 1996. In December 1995, HMO Oregon alone enrolled 41 percent of OHP members, climbing to nearly 43 percent as of July 1996.

We expected the level of concentration to increase further with the termination of several plan contracts in August and September of 1996 (PacifiCare, PACC, and QualMed). However, this was not found to be the case. HMO Oregon's statewide market share dropped to 33 percent as of July 1997 (from 43 percent a year earlier). A new plan, Central Oregon Independent Health Services (COIHS), grew to 6.7 percent of the OHP enrollment with the expansion of its service area into counties previously served by other plans. Together, the top six plans (each with shares of 5 percent or more) accounted for 66 percent of OHP enrollees. This represents a reduction in the level of concentration over time and reflects the growth of regional health plans. The statewide plans are losing dominance, while local plans are gaining market share.

Financial Performance of Prepaid Health Plans. An analysis was performed of the financial performance of the 20 health plans participating in OHP during calendar year 1994 through the third quarter of 1995. The aggregate OHP premiums paid to these plans

amounted to $542 million. HMO Oregon, with $223 million in premiums, accounted for 41 percent of the total. Ten of the 20 plans were profitable, and ten were not. Aggregate net income ranged from a $1.4 million loss for HMO Oregon to a $1.8 million gain for the Medford Clinic. Moreover, the percent net income (or profit margin) ranged from -12 percent for both Coordinated Healthcare Network and QualMed to +45 percent for the Medford Clinic.[7] In total, however, the plans reported that they lost half a million dollars on OHP, for an aggregate average profit margin of -0.1 percent. That is, the quarterly reported financial data imply that the health plans basically broke even on OHP *in the aggregate*. However, all but one of the plans that has terminated its contract with OHP incurred a financial loss. Also of concern is the financial status of the top-five plans, which together enrolled 73 percent of OHP members as of the July 1996. Again, all but one had a financial loss, and the other had only a nominal gain.

The Oregon Health Plan Benefit Package

The Oregon Health Plan benefit package is based on a prioritized list of health services. The priority list consists of paired conditions and treatments ranked hierarchically from most to least medically necessary or appropriate. Covered services are those above a cut-off line that is determined according to the level of resources available to fund the

[7] Columbia Managed Care (now defunct) reported a profit margin of -26 percent.

program. Services "below the line" are uncovered, except in cases where there is a comorbid condition that would qualify for coverage.

The priority list was intended to assist the State in rationing the services, not the people, that would be covered by the Medicaid program. The theory was that the State could expand insurance coverage to more low-income uninsured people (who were not otherwise categorically eligible for Medicaid) by eliminating coverage for treatments that were not proven effective, or for conditions which improved on their own. The list of covered benefits would be reduced when the State faced a budget shortfall, as opposed to restricting eligibility or cutting provider fees.

Provider Responses to the Priority List. The priority list has provided the health plans with a document with which to identify services that are covered under the Oregon Health Plan. The health plans can describe to providers the specific services for which they will be paid. In turn, the providers can use the list to explain to patients which services will and will not be covered by OHP. Most providers have an understanding of what falls below the cut-off line, but how this information is translated into practice differs from plan to plan and from provider to provider.

Within the State, there is virtually unanimous praise for the list. In fact, the list of covered services is quite extensive, and represents an expansion of benefits received under the traditional Medicaid program (e.g., preventive care for adults, dental care for adults, hospice care, and transplants for adults), while few services of consequence are being denied. Some providers have decided to continue to practice medicine as they always

have in the past, not distinguishing an OHP patient from a patient with private insurance. If care is provided for which no reimbursement is provided, then the provider simply is not paid for services rendered. An example of this behavior involves the surgical management of adults with symptomatic hernias. Although not covered by the current priority list, young working men with symptomatic hernias often cannot work when their job involves lifting. Some provider groups have decided to fix the hernia even though they won't be paid. In Roseburg, the hospitals have had a "hernia day" on a weekend, where the surgeons donated their time and the hospital donated its operating room.

Other approaches to providing care may involve a creative use of the priority list. For example, tonsillectomy and adenoidectomy fall below the cut-off line on the priority list. However, there is a guideline specifying that tonsillectomy and adenoidectomy will be approved when the enlarged tissue is associated with obstructive sleep apnea related to upper airway obstruction. The frequency of obstructive sleep apnea among children and adolescents is believed to be increasing as a result of this coding phenomenon.

The impact of the priority list on provider practice patterns is an empirical question. Our provider surveys will assess the impact of the priority list on provider practice patterns. In addition, we hope to undertake claims/encounter data analysis to assess patterns of care before and after OHP implementation.

The Role and Future of the Priority List in the OHP Demonstration. The priority list is central to the OHP demonstration because it is intended to provide a mechanism for the State to allocate resources within a given budget constraint. The State

has found that the priority list is a difficult way to manage a fiscal crisis. HCFA must approve all line changes before they can be implemented by the State. While awaiting HCFA approval of line changes, the State has had to look for other means of controlling costs. The State feels this is counter to the original intent of the demonstration.

A salient question is: How much higher can the line be raised, and still be considered a "basic benefit package"? HCFA denied the State's recent request to raise the line to line 573, approving a movement only to line 578. Whether this limits all future line movements remains to be seen.

In the meantime, some stakeholders would prefer that the State allow health plans to impose limits on the number, frequency, or annual costs of diagnostic services, physical therapy encounters, and/or mental health services, similar to those in commercial benefit packages. The problem with this approach, however, is that if OHP benefit limits begin to resemble commercial benefit packages, there is no longer a safety net for those with more intense and complex medical needs.

The Oregon Health Plan has faced budget shortfalls virtually every year, requiring interim requests for changes in the cut-off line, changes in the eligibility criteria, reductions of health plan and FFS payment rates, and other policies designed to reduce OMAP spending. To date, the Oregon Health Plan has shown that the priority list alone is not enough to manage budget shortfalls. Moreover, it remains to be seen whether further line movements will be possible while still preserving a basic benefit package.

Employer and Private Health Insurance Issues

The Oregon Health Plan was implemented in the context of a broad statewide health insurance reform effort in Oregon. The Medicaid demonstration constitutes the Federally-funded part of this broader effort. Although the employer mandate and the small business insurance programs are separate from the Medicaid demonstration, they are important to its success. The waiver cost estimate for the Medicaid program assumed that Medicaid beneficiaries who are employed would shift to employer coverage by February 1997. Under the assumption of Federal budget neutrality, the program may not be able to meet projected expenses with the demise of the employer mandate, unless the State contributes additional State revenues or reduces program costs. Options included:

- Imposing additional taxes,
- Shifting existing State revenue from other uses,
- Lowering capitation rates from reasonable cost to some lower proportion of cost,
- Introducing copayments and/or deductibles,
- Introducing premiums,
- Raising the line on the priority list,
- Excluding selected groups of persons from coverage.

The last three options on the list were implemented in FY 1996. In November 1996, approval of Ballot Measure 44 authorized a tax on tobacco products to support expansions of the Oregon Health Plan. Three expansions are planned for 1998 using these funds. The first two expand Medicaid eligibility to: (1) reinstate approximately 1,700 full-time college

students who are eligible for Pell grants (college students were made ineligible in FY 1996 because of budget limitations) and (2) cover 1,800 additional pregnant women and 25,000 children through age 11 under the Poverty Level Medical (PLM) program. The third expansion involves the private insurance market. The Family Health Insurance Assistance Program (FHIAP) will subsidize private insurance premiums for group or individual coverage for approximately 20,000 adults and children, easing the potential budget problem caused by the loss of the employer mandate.

Impact of OHP on Providers

Provider Support for OHP. Providers were among the key supporters of the Oregon Health Plan (OHP) during its inception and development.[8] They favored the expansion of Medicaid eligibility to improve financial access among the uninsured (and reduce the level of uncompensated care). Moreover, with the increased fees to minimize cost-shifting, Medicaid reimbursement was viewed more favorably by the private medical community.

Physician concerns centered on the accelerated growth and diffusion of managed care, and the implementation of a prioritized list of benefits. Although managed care was prevalent in Oregon prior to OHP, it was concentrated in the Portland metropolitan area and a few other urban pockets. Under OHP, managed care was destined to spread virtually

[8] In fact, the program's architect (and now Governor), John Kitzhaber, is a physician.

statewide. Furthermore, implementation of the priority list was a complete "unknown." While in theory, there was widespread support for the prioritization of benefits, physicians were not sure how it would affect their practices in reality.

At the outset, public and community-based providers were less certain about their role in OHP. Long the providers of last resort when private providers closed their doors to indigent patients, it was unclear how Federally-qualified health centers (FQHCs) would fare when they were no longer assured cost-based reimbursement, and when they faced increased competition for patients. The role of public health departments was evolving as well.

As part of our evaluation, we sought to understand how private and public providers had been affected by the Oregon Health Plan, including the impacts of managed care, the introduction of the priority list, and the expansion of Medicaid eligibility. Our approach was to conduct intensive site visits in three communities in Western Oregon -- Hood River, Roseburg, and Salem. We met with private practice physicians (primary care and specialists), physician office staff, public health department directors, hospital administrators and emergency room staff, and the staff of Federally Qualified Health Centers (FQHCs) and other clinics. All visits took place during October 1995.

The three communities were chosen primarily because of the competitive environment in which OHP was implemented. Physicians in Roseburg, for example, chose to form their own Independent Practice Association (IPA) and contract directly with the State as a prepaid health plan under OHP. Their plan has become a model for other communities that are beginning to form regional IPAs that can contract directly with OHP. Salem faced

considerable provider shortages *before* OHP, but consumer advocacy in the community brought about creative solutions to the capacity problem during OHP. Hood River was chosen because it is a relatively rural county, with a substantial seasonal and migrant population. An FQHC serves the migrant, largely Hispanic, population.

Establishment and Evolution of IPAs. In all three communities, physicians are organized in local Independent Practice Associations (IPAs) as a vehicle for increasing negotiating power with managed care organizations. Each of the three IPAs includes almost every physician in the community. The IPAs act as the contracting agent and fiscal intermediary for members, and in Salem, the IPA is taking on responsibility for almost all quality assurance activities. In Roseburg, the IPA has been so successful in operating its OHP health plan that it is now seeking commercial contracts as well. Roseburg's success has spawned the creation of other regional IPAs, which are seeking OHP and/or commercial contracts. The IPA in Hood River was formed just prior to OHP to contract with health plans. Recently, the IPA discontinued its contract with two statewide plans and entered into an agreement with a new regional plan (begun by an IPA in Central Oregon). Physicians in Hood River and Roseburg felt that the local or regional plans were more responsive to local providers, and offered more cost and utilization data with which to monitor performance.

Common Themes. A number of common themes about the impact of OHP on providers were echoed in the provider interviews. First, as discussed above, the priority list has not had a major impact on physician practice. Physicians have found ways to provide

care that they feel is necessary, either by obtaining exemptions from the health plans, or by providing care free of charge (e.g., “hernia days” in Roseburg).

Second, there is a widespread perception that access and capacity has improved, especially for the expansion population. The managed care structure, together with the higher fees that encouraged provider participation, were critical to the success of OHP in improving access to care. Physicians feel that OHP's increased reimbursement rates alone would not have achieved the positive outcomes. In Roseburg, physicians initially sought to limit the number of new OHP patients, but now, will take as many as are available. Physicians praised the improvements but acknowledged that the population which remains uninsured continues to face barriers to care. Additionally, concerns were raised, especially by the public health departments, that there is not enough focus on preventive care.[9] And as with any managed care program, specialists raised concerns over the adequacy of specialty referrals as well as reimbursement rates for specialty care.

Perhaps the most vocal concern raised by providers was related to the provision of after-hours care. In two of the communities, hospitals had been sanctioned for violation of COBRA "anti-dumping" provisions. Providers in all communities noted a fundamental conflict between COBRA's requirements for *physician* screening of all ER patients and an unwillingness of managed care plans to compensate adequately for the costs of triage. This is perceived as an irreconcilable "catch-22" that has profound financial and liability

[9] This is consistent with results of the External Quality Review conducted by OMPRO (1995).

implications for the hospitals. Hospitals have responded by establishing urgent care centers to which they can triage non-emergent patients. But this is viewed as only a partial solution, because a physician still must screen anyone who presents at the ER prior to triage.

Differential Impact of OHP on Public and Private Providers. An important implication of the community case studies is the differential reaction to OHP between the private providers and public agencies. The difference of opinion focuses on the operational aspects of managed care and its cost implications. The private practice physicians and the local community hospitals strongly favor OHP, seeing it as a way to improve the coordination of care for persons who in the past had few, if any, resources available for health care. Moreover, many physicians reported that reimbursement rates have increased and bad debt has decreased.

In contrast, the community-based providers that we interviewed -- the FQHCs and other clinics -- tended to be wary of managed care under OHP and reported problems working with the health plans. The FQHCs and other clinics reported financial losses due to one or more factors, such as decreased reimbursement rates, adverse selection, loss of patients, and significantly higher administrative expenses because of the lack of standardization in policies and procedures across health plans. These providers apparently encountered losses despite receiving increased payments for individuals who were previously uninsured. Loss of patients may be a consequence of increased accessibility to providers who previously were not participating in Medicaid.

Next Steps. Future site visits will follow-up on the themes identified in these provider case studies, and hopefully the investigation will extend to additional communities (especially in Eastern Oregon). Moreover, the provider survey, which will include over 1,000 physicians and agencies, will obtain quantitative estimates of provider reactions to OHP and how the program has affected their practices. Special attention will be given to the impact of OHP on providers who treat people with disabilities.

Impact of OHP on Consumer Access

The Oregon Health Plan was designed to improve access for traditional Medicaid enrollees by: (1) increasing Medicaid fees as an inducement to provider participation, and (2) accelerating the growth of private managed care to bring new providers into the program. The OHP eligibility expansions were designed to remove financial barriers to care experienced by the low-income uninsured who were categorically ineligible for Medicaid. Most of our current impressions about the impacts of OHP on access to care are based on anecdotal evidence, through case study interviews and analysis of secondary sources. Empirical information is not yet available for the evaluation.

Findings from State Surveys. The State has conducted two waves of a survey comparing levels of satisfaction before and after OHP was implemented. Not only did satisfaction with the choice of primary care providers increase, but also satisfaction with the ability to get medical care whenever it is needed. Thus, Phase I clients appear to be more satisfied with the shift to managed care and the implementation of the priority list than they

were under traditional Medicaid. Similarly, another State survey of newly-enrolled women ages 52-64 found higher rates of physician use, including routine check-ups and mammograms, following enrollment in OHP. This evidence suggests that the expansion of financial access through OHP, and perhaps the emphasis of managed care on preventive care, has resulted in increased rates of preventive care use.

Access to Maternity and Dental Care. We also reviewed anecdotal evidence concerning access to maternity care and access to dental care. The State encountered challenges in meeting the dental care needs of the OHP population, in part because of longstanding shortages of dental providers, but also because of high levels of pent-up demand and a generous benefit package which until recently had few limits. The State has responded by issuing guidelines for dental care, establishing new dental care plans and new dental clinics, and providing mobile dental services for individuals with special dental needs.

The State also faced unanticipated challenges in the shift of pregnant women to managed care. Due to the OHP application process, women encountered delays in obtaining referrals to prenatal care. Referrals to maternity case management services dropped as a result of lack of health plan and provider familiarity with the services. The State has instituted administrative procedures to expedite the processing of applications for pregnant women. In addition, the State has eliminated the need for a referral to an OB provider (including certified nurse midwives). Both of these mechanisms should ensure more timely initiation of prenatal care. The State also has instituted outreach and education services

regarding maternity case management services, to alert both providers and beneficiaries about their availability.

Next Steps. The evaluation will continue to monitor access and satisfaction through such mechanisms as case study interviews, focus groups, telephone surveys, and encounter data analyses. In particular, we will be comparing levels of access and satisfaction among low-income individuals enrolled in OHP versus those who are privately insured or who remain uninsured.

1 Introduction

The Oregon Health Plan (OHP) is an innovative effort by the State of Oregon to extend health insurance coverage to uninsured State residents below poverty. The costs of expanded insurance coverage are financed through the use of a prioritized list of health care services (to determine the benefit package), increased enrollment in capitated managed care organizations (MCOs)[1], as well as revenues generated by a cigarette tax earmarked for OHP.

The Oregon Health Plan was implemented in February 1994 under a Section 1115 waiver from the Health Care Financing Administration (HCFA). As a Section 1115 demonstration program, the OHP is being evaluated through a HCFA-funded evaluation contract. The evaluation addresses both the implementation process and program impacts, using qualitative and quantitative approaches.

This report is the First Interim Report produced by the evaluation. The report focuses on the evolution of OHP from the perspectives of State officials, the MCOs, local providers, and consumer advocates. This chapter traces the origins of OHP and then provides an overview of the external evaluation of OHP.

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[1] The *managed care expansion* builds on a previous 1915(b) waiver program in which Aid to Families with Dependent Children (AFDC) Medicaid beneficiaries were mandatorily enrolled in managed care settings in fifteen counties and voluntarily enrolled in two counties. Under OHP, however, enrollment in fully capitated health plans (FCHPs) is mandatory in most counties (and in most ZIP codes in those counties).

1.1 Historical Context

The Oregon Health Plan developed within the context of a rapidly growing State Medicaid budget, a large and growing uninsured population, and limited physician participation in the Medicaid program. Legislators routinely faced Medicaid budget crises during the 1980s, which they temporarily resolved by cutting benefits, restricting eligibility, or reducing provider payments.

The philosophical basis for the Oregon Health Plan dates back to 1987 when payment for major organ transplants was discontinued. Public outcry prompted a more rigorous examination of the criteria employed in determining eligibility and service coverage under the State's Medicaid program.

This ultimately led to the development of a prioritized list of conditions and treatments that would be used to determine the content of the benefit package. The intent was to *rationalize* the allocation of health care resources through the prioritization of services, and hence, use the savings to expand coverage to more uninsured people.

The prioritization of health services represents a fundamental redirection of State Medicaid policy to limit what *services* are covered rather than which *people* are covered. "Explicit" rationing under OHP using the priority list is in contrast to the previous "implicit" rationing of care through fee reductions imposed on providers or eligibility reductions targeted at selected populations.

Thus, the unique feature of OHP is that it expands eligibility for Medicaid, but to stay within State budgetary constraints, it limits the types of services that are covered. The

implication of such a process is that services provided to the covered population could vary every two years (each budget biennium) or more often, based on the funds allocated and approved by the Legislature.

1.2 Legislative Origins

One of the key components that paved the way for implementation of the demonstration was the "up-front" legislative process that took place before the waiver application was prepared. Senate Bill 27 was enacted in 1989 and provided the foundation for the Oregon Health Plan. The legislation contained four basic premises:

- The State would take responsibility for insuring legal State residents with incomes below the Federal poverty level, without regard to categorical criteria.
- The State would develop a prioritized list of health services (ranked according to clinical effectiveness and social value) and the scope of benefits would be tied explicitly to the budget process. Services above the cut-off line would be funded; those below the line would not be covered.
- The State would set reimbursement levels sufficient to cover costs, to eliminate cost-shifting and to increase provider participation.
- The State would make an overt commitment to managed care where feasible.

In addition to the Medicaid reforms, the Oregon Health Plan contained private sector initiatives to expand private insurance coverage. The overall goals and strategies were as follows:

- **To extend private (subsidized) coverage to uninsurable individuals**, through the creation of a high risk insurance pool that would cover those with a pre-existing condition or large anticipated health care costs. Premiums would be capped at 150 percent of the cost of an average premium.

- **To require private coverage of the employed population**, through a mandate that employers: (1) offer insurance to their employees and their dependents (and receive a tax credit), or (2) pay into a State-sponsored Small Business Insurance (SBI) program. The Employer Mandate, authorized under SB27, will not be implemented. Chapter 6 of this report provides further information on the status of private sector initiatives.

The State of Oregon submitted its Section 1115 waiver application to HCFA in August 1991. The waiver application was approved in March 1993, after several revisions of the prioritized list of health services to comply with the Federal Americans with Disabilities Act (ADA). Following a ten-month start-up period, the program began enrolling individuals on February 1, 1994. Phase I of the demonstration included all traditional Medicaid eligibles other than the aged, blind/disabled, and children in foster care, as well as those who were newly eligible under the poverty-level expansion. Phase II, which began on January 1, 1995, brought most of the remaining traditional Medicaid eligibility groups into OHP. The initial response was overwhelming. The waiver application projected that

about 46,800 newly-eligible people would be enrolled in the first year. This level was achieved within just three months.

1.3 Overview of the Evaluation

The evaluation seeks to examine the implementation and impacts of OHP's three main interventions: (1) expansion of managed care within the Medicaid population; (2) establishment of universal access to health coverage for those below poverty; and (3) prioritization of service coverage for Medicaid enrollees. The evaluation includes both a qualitative assessment of the process used to implement OHP and a quantitative analysis of the outcomes achieved by the program.

The **process assessment** contains four main domains related to program operations:

- Eligibility determination and managed care enrollment,
- Managed care contracting and provider participation,
- Employer and private insurance issues that affect OHP enrollment, and
- Implementation of the priority list.

Our design includes a thorough case study component to gather qualitative information that can be used to generate hypotheses for the empirical work or to put the empirical results in a programmatic context. Through the case study component we have learned, and continue to learn, how the program is evolving over time. An extensive on-site presence is planned throughout the evaluation to capture changes in policies and practices.

The goal of the **outcome assessment** is to test whether changes in the Medicaid program had a measurable impact on quality, access, utilization, costs, and satisfaction. One

of the yardsticks against which the demonstration will be measured is the quality of the care delivered. Our design includes a comprehensive quality of care analysis that brings together multiple primary and secondary data sources to validate and cross-validate findings related to the processes and outcomes of care. Medical record abstraction and telephone surveys will focus on three tracer conditions – pediatric asthma, insulin-dependent diabetes, and low back pain (a below-the-line condition). Administrative data analyses based on claims/encounter data will document changes in practice patterns as well, to the extent the data permit.[2]

We also are concerned with the acceptability of the program to its major stakeholders, namely program enrollees and providers. Our design includes comprehensive surveys of enrollees and providers. The *household survey* will assess health status, access, satisfaction, and impact of the priority list, for adults and children separately. The *physician survey* will examine reasons for participation (or nonparticipation) in the program, satisfaction, and responses to the priority list.

An underlying theme of our outcome assessment will be the impact of the demonstration on potentially vulnerable populations. These are the groups at greatest risk of experiencing adverse, unintended consequences. Vulnerable populations include people with a chronic condition (pediatric asthma or diabetes), people with a below-the-line condition (low back pain), and pregnant women.

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[2] We have undertaken an assessment of managed care encounter data submitted by the managed care plans for services performed during 1994. The 1994 data were found to be quite incomplete when compared with pre-OHP data. Additionally, considerable variability among plans was documented (Haber and Rosenbach, 1997).

1.4 Scope and Organization of this Report

This report discusses how the Oregon Health Plan program has evolved since it was implemented in February 1994. The report is based on three site visits conducted in November 1994, October 1995, and June 1996, as well as analyses of secondary data maintained by the State. Data sources include the monthly enrollment and disenrollment reports, audited financial statements from managed care plans, and other administrative reports. Additional phone follow-up occurred on an as-needed basis.

The focus of this report is on the Phase I population, that is, the "current" eligibles who were rolled over from the traditional Medicaid program into the Oregon Health Plan as well as the "expansion" eligibles who became eligible for OHP with the eligibility expansion. This analysis does not focus on the Phase II population -- the aged, blind, and disabled, and children in foster care -- who enrolled in OHP effective January 1, 1995. The Phase II population is the subject of future reports.

This report contains seven additional chapters. Chapter 2 describes the organizational changes that took place within the State Medicaid agency as it was transformed from an "indemnity insurer" to a managed care contractor. Chapter 3 discusses the eligibility and enrollment procedures and trends, while Chapter 4 focuses on trends in managed care contracts and financial status. Chapter 5 describes the implementation of the priority list and initial reactions to the list. Next, Chapter 6 examines employer and private health insurance issues and their interaction with the Medicaid demonstration. Chapters 7

and 8 present case study results of the impact of the Oregon Health Plan on providers and consumers, respectively.

2 Changes in Program Organization

One of the challenges faced by a State Medicaid agency in implementing a Medicaid managed care program is to transform its organization from a fee-for-service indemnity insurer to managing contracts with capitated managed care organizations (MCOs). No longer is the Medicaid agency charged primarily with setting fees, paying bills, and monitoring for fraud and abuse. With the increased emphasis on "privatization," the State Medicaid agency is required to:

- issue requests for applications (RFAs) from managed care organizations;
- evaluate bids from the standpoint of access and quality assurance provisions;
- set capitation rates (or evaluate competitive bids) to minimize incentives for adverse selection and underservice;
- ensure that eligibility and enrollment data systems are in place and compatible with the MCOs' systems;
- develop encounter data systems to facilitate monitoring, evaluation, and rate-setting;
- perform ongoing monitoring and evaluation of quality and access.

This chapter describes the transformation of Oregon's Medicaid agency throughout the design, implementation, and operation of the Oregon Health Plan (OHP).

2.1 Pre-Demonstration Organization: Design and Implementation

The Office of Medical Assistance Programs (OMAP) administers the State's Medicaid program and is responsible for the design and implementation of the Oregon Health Plan. Initial responsibility for planning the demonstration was located within OMAP's **Prioritized Health Care Unit**, a dedicated staff of five professionals, which had been operational since 1989. OMAP's five other units carried out the operations of the ongoing Medicaid program and assisted in demonstration implementation (see Exhibit 2-1). For example, the Health Program and Policy Unit (HPPU) was integral in making clinical and policy decisions related to implementation of the priority list. The Provider Relations Unit (PRU) conducted intensive provider education, especially related to the priority list and encounter data issues.

Upon approval of the Section 1115 waiver application in March 1993, OMAP was reorganized to provide a focal point for managed care activities within the agency (see Exhibit 2-2). The Prioritized Health Care Unit was integrated with existing staff from the Alternative Delivery Systems Group, to form the **Managed Health Care Unit** (MHCU). Charged with the lead role in the demonstration project, the MHCU was responsible for ensuring compliance with HCFA requirements, overseeing program and policy development, and managing program monitoring, research, evaluation, and utilization. In addition, the MHCU engaged in quantitative and qualitative analysis, rate setting analysis, and assuring that individual health plans were managing themselves appropriately to remain financially viable.

Exhibit 2-1

Organization of the Office of Medical Assistance Programs
For Design and Implementation of the Oregon Health Plan (OHP)

Pre-OHP Unit Name	Pre-OHP Responsibility	OHP-Related Responsibilities
Prioritized Health Care Unit (PHCU)	Responsible for designing demonstration; established in 1989.	Merged with Alternative Delivery Systems Group to create the Managed Health Care Unit (MHCU), to provide a focal point for OHP demonstration implementation, monitoring, and evaluation. MHCU later merged with Health Program and Policy Unit (HPPU) to create the Program and Policy Unit (PPU).
Health Program and Policy Unit (HPPU)	Responsible for overseeing delivery of services to fee-for-service recipients and Oregon's 1915(b) Medicaid managed care program.	Policy and clinical decision-making entity within OMAP for implementation of the priority list. Later merged with the Managed Health Care Unit to create the Program and Policy Unit (PPU), eliminating duplication of responsibilities in overseeing the fee-for-service and managed care delivery systems.
Quality Assurance Unit (QAU)	Primarily responsible for monitoring provider billing and recipient utilization with respect to fraud and abuse.	Responsibilities reallocated to (1) MHCU Analysis and Evaluation Subunit for monitoring provider compliance with administrative rules and (2) Quantitative Analysis Subunit to support capitation rate-setting and other budget-related tasks.

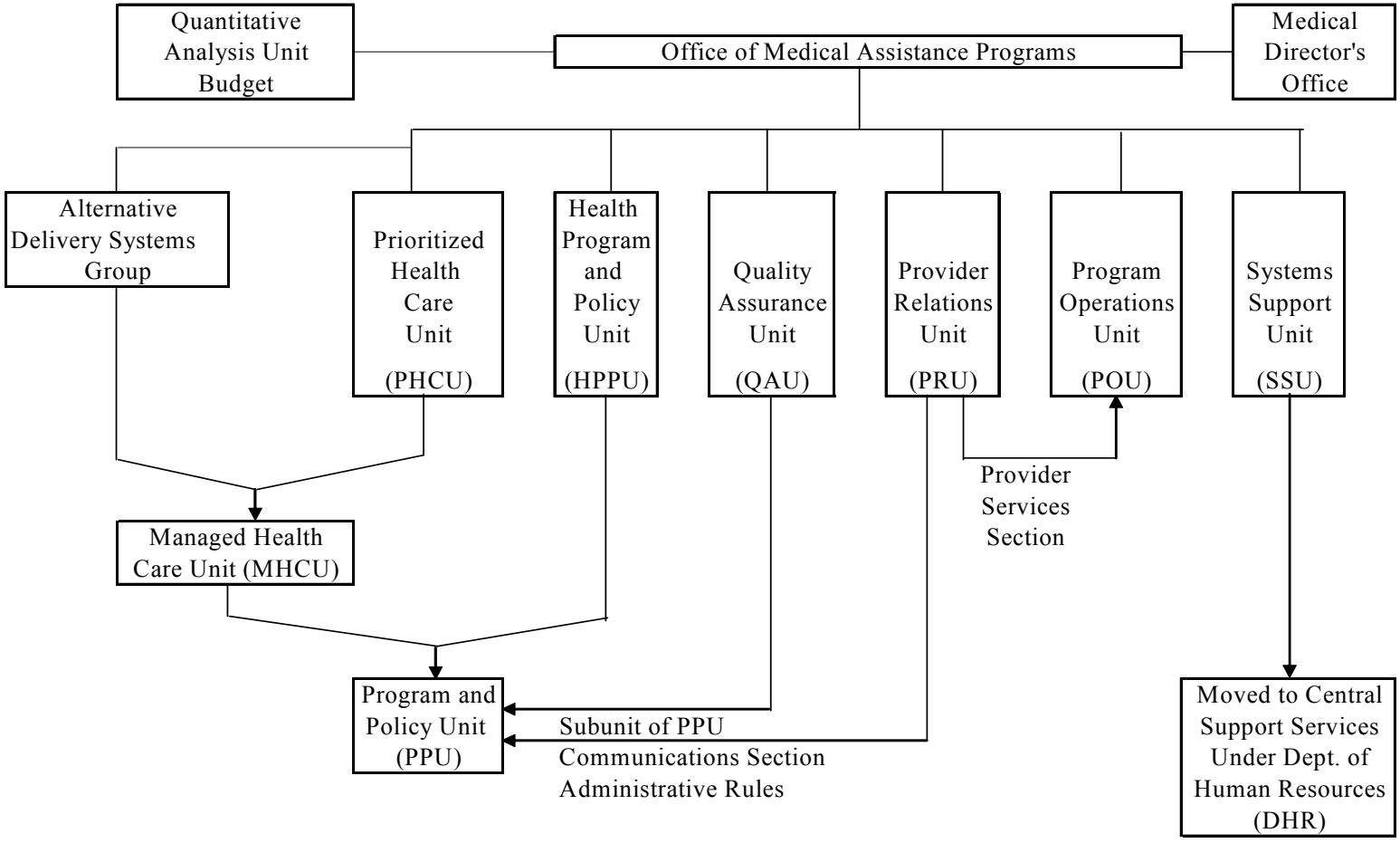
Exhibit 2-1 (continued)

Organization of the Office of Medical Assistance Programs
For Design and Implementation of the Oregon Health Plan (OHP)

Provider Relations Unit (PRU)	Responsible for recruiting, credentialing, training, and retaining physicians and other providers.	Increased responsibility for communications and training, especially with regard to the benefit design, encounter data submission, evaluation, and quality assurance. The written communications part of this unit merged with the PPU. The provider services functions merged with POU.
Program Operations Unit (POU)	Handled the daily operations of OMAP's programs, including claims process and eligibility tracking.	Continued responsibility for claims processing; added responsibility for producing encounter data and handling increased volume resulting from eligibility expansions.
Systems Support Unit (SSU)	Responsible for developing and maintaining Oregon's Medicaid Management Information System (MMIS) and allowing Oregon to process its own claims rather than contract with a fiscal intermediary.	Responsible for incorporating MMIS enhancements, including systems for paying FFS claims under the priority list; eligibility and enrollment data for making capitation payments to health plans; and modules for collecting and analyzing encounter data. Has now merged with other DHR systems support units to form an integrated DHR Office of Information Systems.

Exhibit 2-2

Evolution of the Office of Medical Assistance Programs (OMAP) Organization



The **Medical Director's Office** (MDO) emerged as a separate unit within OMAP in late 1993 just prior to the inception of OHP. The Medical Director's Office is responsible for policy development, clinical reviews, practice guidelines, and prior authorization for out-of-state and fee-for-service transplants. In addition, a Benefit RN Hotline was established in the Program Operations Unit in response to HCFA's Special Terms and Conditions in order to resolve provider questions about using the prioritized list. The Benefit RN Hotline also coordinates with the MDO to review requests for "grandfathered services" and coverage of comorbid conditions. The MDO has recently focused on defining roles for public health departments under managed care, fostering provider and client education related to managed care, and addressing delivery system issues associated with preventive services and perinatal access and care.

2.2 Post-Demonstration Reorganization: Consolidation and Streamlining

Following the Phase I implementation of OHP, OMAP began a series of organizational changes, characterized mainly by streamlining and consolidation of the fee-for-service operations. For example, no longer was it necessary to maintain dual quality assurance units, one for fee-for-service and another for managed care. Therefore, in late-1994, the Analysis and Evaluation subunit within MHCU assumed the "medical audit" and financial monitoring responsibilities of the Quality Assurance Unit. A new Quantitative Analysis Subunit was created under the direction of the OMAP Assistant Director to elevate the rate-setting function within OMAP.

An important development within the MHCU was the creation of the OHP Ombudsman Office on March 1, 1995. The Ombudsman Office provides assistance to clients having difficulty accessing or obtaining OHP services. Ombudsman staff serve as advocates for eligible clients with concerns about access, to or receipt of, health services but who are not independently able to pursue solutions. In addition to assisting individual clients through administrative rules, provider guides, agency procedures and health plan protocols, the staff also respond to concerns from medical providers, prepaid health plans (PHPs, including both fully capitated health plans and physician care organizations), and agency workers related to Phase II of the OHP. The development of the Ombudsman position illustrates OMAP's creativity and flexibility in adjusting to the changing needs of OHP clients.

In June 1995, the MHCU merged with the **Health Program and Policy Unit** (HPPU) and formed the **Program and Policy Unit** (PPU). Consolidation of these two units is a prime example of OMAP's adaptive streamlining as the program matures. The former responsibilities of the HPPU had been primarily fee-for-service policies and procedures and the integration of the priority list into the Medicaid program. Although the merger was precipitated by the departure of the HPPU Unit Manager, OMAP's decision to combine the two units acknowledged that managed care is now OMAP's primary delivery system, as fee-for-service accounts for less than 20 percent of all OHP eligibles.

Additional streamlining occurred in 1996, when OMAP's units were further consolidated into two sections. Program and Policy incorporates the delivery system, analysis and evaluation, communications, and policy units. Program Operations is

responsible for encounter data systems, claims processing, enrollment tracking, operation of the benefit hotline, and other administrative functions.

OMAP's process of streamlining runs contrary to the original prediction of a permanently expanded staff. After the initial staff expansion prior to the Phase I implementation in February 1994, OMAP has since conducted a gradual downsizing of its staff. The majority of OMAP staff cuts have been within the claims processing area as a result of the reduction in processing requirements for fee-for-service claims. In addition to addressing budget constraints, the decrease in staff is viewed by OMAP as an indication of a maturing program whereby much of the administrative support previously necessary for implementation has now become superfluous in an operational program. Furthermore, as OMAP gains experience, it has taken the opportunity to shift its focus away from an "operations" role and more towards a monitoring function.

In contrast to the significant reductions within OMAP's fee-for-service areas, the PPU had undergone steady growth within its own organizational structure. The PPU has increased its hiring of Prepaid Health Plan (PHP) Coordinators to facilitate OMAP's interaction with PHPs and PCCMs. It also added three program coordinators within its Analysis and Evaluation Subunit, two of whom are Site Review Coordinators and the third is a Research and Evaluation Coordinator.

2.3 Creation of New Administrative Entities

The State has faced challenges in coordinating the multi-faceted Oregon Health Plan and ensuring its continued survival within the changing political context. This section describes two organizational initiatives designed to strengthen the administrative capacity of the Oregon Health Plan.

2.3.1 Office of the Health Plan Administrator

Besides the Medicaid demonstration, the Oregon Health Plan involves private sector initiatives, including small market insurance reform, a high risk pool, and a voluntary tax credit program. These efforts were not being coordinated effectively with each other; State officials became concerned that no one person was responsible for overseeing all of the public and private sector initiatives for the working poor. Thus, a new position, the Office of the Health Plan Administrator (OHPA), was established within the Department of Administrative Services to coordinate OHP's various public and private sector components. Created by the 1993 Oregon Legislative Session, the OHPA was established to "promote universal access to an adequate level of high quality health care at an affordable cost."

OHPA is a crucial partner to OMAP in the governance of OHP, working cooperatively and collaboratively with OMAP in coordinating health care activities in the State. The OHPA is concerned with reviewing and evaluating current components of the OHP. For example, the OHPA has engaged in an analysis of OHP impacts on the State economy, and the coordination of issues and recommendations associated with private

insurance initiatives. The formation of the OHPA allowed for a central body to foster extensive networking and communication among State officials, health care interest groups, businesses, and various social service organizations.

In December 1995, the OHPA merged with the Department of Human Resources (DHR) Office of Health Policy. Passed during the 1995 Oregon Legislative session, Senate Bill 1079 called for the consolidation of the two offices in a continuing effort to provide Oregon with a central source of information regarding the OHP and Oregon health reform efforts. The Office of Health Policy was responsible for health care capacity planning and overseeing the Health Services Commission (HSC), the Health Resources Commission (HRC), and the Oregon Health Council.

The OHPA was also responsible for the Consumer Scorecard Project. The purpose of a consumer scorecard is to provide health plan information to aid the general public in the selection of a managed care plan. The consolidation of the two offices involved with the project, coupled with the addition of OMAP's Analysis and Evaluation staff as members on all five scorecard subcommittees, centralized the development of the consumer scorecard and other research endeavors. The Consumer Scorecard Project is discussed in greater detail in section 3.8 of this report.

In 1997, the State legislature changed the name of the OHPA to the Office for Oregon Health Plan Policy and Research. The name change occurred due to confusion over the role of OMAP versus OHPA vis-a-vis the administration of OHP.

2.3.2 Federal Policy Coordinator

Another important organizational development was the creation of the Federal Policy Coordinator position within the Governor's office. In September 1995, the former Director of OMAP and Acting Director of DHR assumed the position of the Governor's Federal Policy Coordinator, where she was responsible for monitoring, at the national level, events which impacted Oregon's health-related interests. At the time, Congress was actively debating the future of the Medicaid program, and the fate of Section 1115 demonstration programs was in jeopardy. Oregon was highly sensitive to this fact and created the Federal Policy Coordinator position to represent the State's concerns during the debate.

2.4 Stakeholder Involvement

The State has demonstrated strong commitment to stimulating provider and consumer participation in the decision-making process. OMAP credits their early and ongoing involvement of stakeholders with the bipartisan support for the program. Unlike many states, Oregon had already established the enabling legislation for the Medicaid Reform Demonstration prior to the development of the actual waiver application. In 1989 and 1991, the State legislature passed S.B. 27 which extends Medicaid eligibility to the uninsured below the federal poverty level, S.B. 935 which encourages coverage for employees and their dependents, S.B. 534 which makes coverage available to those with pre-existing conditions, and S.B. 1076 which makes insurance more affordable and available to small employers. Through this legislative process, the State was able to generate consensus among

stakeholders (providers and consumers) up front and express basic values to the public. This involvement of stakeholders (including advocacy groups) has continued throughout the planning and implementation of OHP.

A high level of involvement among the health plans was also evident from the beginning of the program. OMAP, in its annual report on the progress of the OHP, acknowledged a "spirit of cooperation" between the DHR and participating health plans. It cites the QA Coordinators' self-initiated Quality Management Coalition, Medical Directors' meetings, and Contractors' meetings as indications of the commitment to the mutual goals and objectives of OHP. Such examples highlight OMAP's efforts to maintain strong community support and demonstrate its flexibility in adjusting to the changing needs of OHP clients and the health care community.

3 Eligibility and Enrollment

One of the key challenges the State Medicaid agency faced in the first year of the Oregon Health Plan (OHP) was in processing applications for the newly-eligible population. Response to the program exceeded all expectations and required program adaptations to accommodate the demand. This chapter describes the eligibility criteria, both those established at the outset of the program as well as modifications made during the second year. The application procedures are discussed next, followed by the role of the enrollment contractors. OHP eligibility trends, in the aggregate as well as disaggregated by category of eligibility, also are presented.

This chapter also discusses the procedures used for health plan choice counseling and selection and summarizes recent trends in managed care enrollment. The experience with eligibility recertification is presented, along with an analysis of health plan disenrollment rates. Higher-than-expected disenrollment rates have been a source of concern (and unanticipated administrative cost) for health plans and providers.

This chapter reflects information gathered during on-site visits, from secondary data sources (primarily monthly summary enrollment and disenrollment reports), and quarterly progress reports prepared by the State. Future analyses of eligibility, enrollment, and disenrollment patterns will be performed based on individual-level administrative data.

3.1 OHP Eligibility Criteria

3.1.1 Original Criteria

One of the original objectives of the Oregon Health Plan (OHP) was to provide health insurance to every Oregonian whose income falls at or below the Federal Poverty Level (FPL). Phase I of OHP, which began February 1, 1994, included two groups of eligibles: (1) the "current" eligibles who were previously eligible for Medicaid, that is, all categorical Medicaid eligibles except the aged, blind, and disabled and children in substitute care; and (2) the "expansion" eligibles, with income up to 100 percent of FPL, who were previously ineligible due to categorical eligibility criteria. Expansion eligibles include two subgroups: single adults/couples and new families. Phase II of OHP, which began January 1, 1995, included the aged, blind, and disabled and children in substitute care.[1]

In broadening eligibility to provide coverage for all persons at or below the poverty level, the demonstration program changed several eligibility criteria for the traditional categorically-eligible Medicaid population and implemented some standards for the expansion population that differ from those used for the categorically eligible. Under the *original* Phase I eligibility rules, these changes and differences included:

- Financial resources (assets), which are a key factor in AFDC and SSI eligibility, and therefore for Medicaid under the old rules, were not considered under OHP for the expansion population.

- Eligibility for the expansion population and for pregnant women and young children participating in the Poverty Level Medical program was determined by gross income only. Deductions from gross income, such as medical spending, were no longer considered.

[1] Phase II eligibles received the OHP benefit package as of January 1, 1995. The phase-in for managed care enrollment began February 1, 1995.

- Families must file as a unit for the expansion population and pregnant women and young children participating in the Poverty Level Medical program. The income of everyone in the family is considered to be available to everyone else and is, therefore, counted in determining eligibility. Under the traditional Medicaid program, the income of some family members was not counted if it was considered to be unavailable to the family members applying.

- Recertification of "current" eligibles usually is conducted monthly in conjunction with recertification for other assistance programs, although some are recertified at longer intervals, up to one year. The expansion population is recertified every six months.

- Categorically-eligible Medicaid beneficiaries were eligible for three months retroactive coverage under the old Medicaid rules. Under OHP, "current" eligibles are still eligible for three months retroactive coverage, but the expansion population receives no retroactive coverage.

3.1.2 Program Modifications

From the beginning of Phase I through September 1995, any Oregonian meeting the fundamental income criterion was eligible to enroll in the program. In response to budget pressures, OMAP initiated discussions with HCFA about modifying the eligibility criteria to exclude certain persons who were believed to be less vulnerable. With HCFA's approval, OMAP instituted three changes to the original Phase I eligibility rules beginning on October 1, 1995:

- Income is measured as the average of the most recent three months' income instead of the previous month's income alone. The Medicaid program traditionally used only the income for the preceding month, because beneficiaries were recertified monthly. However, since the expansion population is recertified every six months, persons who qualified on the basis of one month of unusually low income could remain eligible for months during which they might not otherwise have been eligible. The three-month average is designed to minimize this possibility.[2]

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[2] In part, this change was brought about in response to a highly-publicized case in which a millionaire qualified for the Oregon Health Plan and then held a press conference criticizing the program.

- Persons with $5,000 or more in liquid assets, excluding house and car, are now ineligible for OHP.
- Full-time college students are now ineligible for OHP unless they are pregnant or in a JOBS program.[3]

Although these changes introduced eligibility restrictions that were not originally intended, the fundamental 100 percent FPL criterion is still in place.

Effective December 1, 1995, OMAP began charging premiums to expansion eligibles, including single adults, childless couples, and new families (including children born before October 1, 1983 who are not otherwise eligible under traditional Medicaid). For a single-person family, premiums ranged from $6.00 per month below 50 percent of FPL to $20.00 per month for those 86 to 100 percent of FPL. For a family of four, the monthly payment ranged from $7.50 (below 50 percent of FPL) to $28.00 (86 to 100 percent of FPL). The State maintains continuous eligibility for the six-month certification period if enrollees are not current in their premium payments; however, beneficiaries are denied recertification if they are not up-to-date when they reapply, unless they have a "hardship exception."

Hardship exceptions were required by HCFA as a way to provide continuing coverage to persons who are unable to pay the premium. To qualify for a premium waiver, beneficiaries must submit either a written application to the State or explain their circumstances to an AFS worker. The criteria under which a beneficiary may be excluded from paying a monthly premium include: zero income level, victim of domestic violence, victim of crime causing loss of money or income, victim of natural disaster, death of a household member, loss of housing, or homelessness.

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[3] However, beginning January 1, 1998, eligibility for some full-time college students will be reinstalled.

Another recent modification to the eligibility process was the requirement that OHP eligibles choose a health plan before they are actually enrolled in OHP. Previously, they were enrolled in OHP on a fee-for-service basis until they had chosen a health plan; however, to minimize the fee-for-service liability, as well as to maximize managed care enrollment, OHP eligibles are now required to choose a health plan before they are enrolled.

3.2 OHP Application Procedures

Applications from the Phase I population are filed through three routes, depending on eligibility category or point-of-contact with the health care system. Persons who are applying for or already receiving other types of public assistance, such as Aid to Families with Dependent Children (AFDC) and Food Stamps (FS), apply through the branch offices of the Adult and Family Services (AFS) Division of the Oregon Department of Human Resources. The caseworkers take applications for all assistance programs, including OHP, and are the source of information for clients on the way the program functions and the choice of health plans.

The second major route of enrollment, used by members of the Medicaid expansion population who are not applying for public assistance, is by telephone or mail. At the start of Phase I enrollment in February 1994, Health Choice was OHP's enrollment contractor. They operated a toll-free telephone call center and conducted public information meetings about OHP. Health Choice operators answered beneficiaries' questions about OHP and mailed applications. After receiving their applications, beneficiaries could call the Health Choice toll-free number for counseling and assistance in completing the application and choosing a health plan. Health Choice performed outreach to the expansion population by

providing information to voluntary social service agencies, conducting seminars for providers and community groups, and developing informational material for distribution to the public.

The third enrollment route is through Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals (DSHs). FQHCs and DSHs are permitted to distribute OHP applications and assist patients in completing them when they appear for care. They are the only providers with this authority, because they are an important source of care for the OHP target population. Other hospitals in the State are not permitted to distribute applications, but they can contact the telephone center (which is now at Oregon Prison Industries; see below) at the time a patient is admitted for inpatient care and initiate an application for the patient. For these cases, known as "hospital holds," the date of application becomes the date on which the hospital first contacts the telephone center. The FQHCs and DSHs are a relatively minor source of applications, but the hospital holds account for a significant percentage.

Applications from all three routes are sent to the AFS central office, which makes the eligibility determination, except for persons ages 60 to 64. Applications for persons ages 60 to 64 are reviewed by the Senior and Disabled Services Division (SDSD). Eligibles are sent a notice specifying the starting date of coverage. Persons who are ineligible receive a denial notice and may appeal to AFS or SDSD. The average length of time from date of application request to date of approval/denial was 22.2 days during the first year of the program. This includes about 8.6 days between the date of request and the date the application was received from the client, and another 13.6 days from the date of receipt to the date of decision by the State (Oregon Department of Human Resources, 1995a).

3.3 OHP Enrollment Contractors

OMAP used an enrollment contractor, Health Choice, to perform outreach, education, and choice counseling during the initial implementation of OHP. Subsequently, OMAP scaled down and then ultimately discontinued the contract with Health Choice, choosing instead to contract with Oregon Prison Industries for day-to-day assistance with enrollment.

The chief characteristic of early enrollment in OHP was the unexpectedly large and rapid influx of newly-eligible beneficiaries. The Health Choice contract was based on an estimate of 4,000 to 5,000 incoming calls per month in the toll-free call center. They began with 5,000 per day (65,000 in the first month alone) and eventually stabilized at around 1,500 per day in June 1994. The unexpectedly high volume placed enormous stress on the AFS and Health Choice resources allocated to OHP. Health Choice was using its contract resources at a much faster rate than expected. They were unable to meet response time standards for answering phone calls and mailing applications and materials. AFS developed a backlog of applications awaiting eligibility determination.

Several changes to the system were made in response to this problem. Health Choice assigned a full-time manager to the OHP project. Overflow calls to the toll-free number were routed to their call center in California, which normally handles Medi-Cal calls exclusively, and additional staff were hired. In July 1994, after the initial rush had subsided, the Health Choice contract was modified to reduce the call center staff, establish new response standards, reduce the number of public information sessions held each month from 200 to 50, and delete the requirements for provider training, speaking to community groups, and printing and mailing applications and brochures. OMAP established a new contract for

printing and mailing applications and brochures with Unigroup, a commercial endeavor of the Oregon Correctional Institute, using prison labor.

At the annual contract renewal on July 1, 1995, Health Choice's scope of work was further reduced. They were required to have the capacity to answer at least 800 incoming calls per day at the call center and conduct 15 outreach seminars per month, all along the I-5 corridor. They used a small fixed staff (i.e., they no longer added temporary staff to handle peak loads) and an automated answering system to cover calls that exceeded capacity. They averaged about 1,000 calls per day, peaking shortly after recertification letters were mailed each month. They also received 4,000 to 5,000 hospital hold calls per month.

The Health Choice contract ended on January 31, 1996 in response to a November 1994 Oregon ballot measure, which required that State contracts be reviewed to determine if the work can be conducted by prison labor. The State concluded that Oregon Prison Industries (OPI), formerly known as Unigroup, could provide the service more efficiently, and OPI assumed responsibility for the OHP call center on February 1, 1996.[4] Thus, the call center and mailing operation were once again combined in a single contract. The public information sessions, which cannot be conducted by inmates, were discontinued. However, after the initial enrollment rush in the Spring of 1994, attendance at these sessions had been poor, averaging only 7 to 8 persons who were seeking help with applications.

OMAP staff reported that they originally decided to use a contractor because they did not have the internal capacity to handle outreach. They also reported that they were able

[4] In addition, in November 1995, Oregon Prison Industries began answering calls to the Provider Services toll-free number through the OMAP Telecommunications Center.

to adapt to the unexpectedly high volume as soon as they did because Health Choice could hire staff much more quickly than the State.

3.4 Health Plan Choice Counseling and Selection

The application package contains the forms needed to establish OHP eligibility and to choose a health plan. Beneficiaries receive a 3-page brochure with eligibility criteria and application instructions, a 4-page application, a 1-page form to report self-employment income, a 1-page form to report other health insurance coverage, a county-specific health plan comparison chart, a notice indicating changes in health plan participation since the enrollment chart was printed, and a 24-page managed care handbook. Each of the 36 county-specific plan comparison charts was translated into eight languages, including Spanish, Russian, Romanian, Hmong, Vietnamese, Laotian, Cambodian and Mien. The 3-page instructional brochure was printed in English and Spanish. All comparative information about health plans is distributed by the enrollment organizations (AFS, the enrollment broker, FQHCs, and DSHs), except for provider lists, which are obtained from health plans. Direct marketing by health plans is prohibited.

Once the beneficiary chooses a health plan, selection of a primary care provider (PCP) is handled by the health plan. When their eligibility is established, beneficiaries are told to contact their health plans for further information about using the health plan. They receive a fee-for-service Medicaid ID card from OMAP and, from the health plan, an ID card and instructions about how to use the health plan's system.

One of the adaptations to the original program design concerned the distribution of provider lists to assist in choosing a health plan. The health plan choice material that OMAP

and Health Choice initially intended to distribute to applicants included the list of providers affiliated with each health plan. However, they found that changes in provider affiliation with health plans and providers' acceptance of new patients were frequent enough so that these lists would be obsolete almost as soon as they were printed. Health Choice and OMAP agreed that sending out incorrect information was less desirable than sending no information at all, even if the absence of provider lists might increase the difficulty of making an informed selection. Consequently, the health plan choice material does not include provider lists. Beneficiaries either obtain lists directly from the health plans they are interested in or they ask their usual physicians which plans the physicians belong to and choose one of those.

Until recently, OHP eligibility could be established at any time during the month, but health plan enrollment would begin on the first of the month following the start of eligibility (or choice of the health plan). Health plans and beneficiaries without a usual source of care prior to OHP eligibility sometimes encountered a timing problem when beneficiaries became eligible and chose a health plan in mid-month. If the beneficiary contacted the health plan immediately, the plan would not yet have been notified of the beneficiary's enrollment. Beneficiaries who needed care immediately (often the reason for enrolling in OHP) needed to find a doctor to see them under fee-for-service. On the first of the following month, when they received a permanent card restricting them to the health plan's PCP, they may no longer have been able to see the doctor who just began treating them. Beneficiaries in this situation often were confused and continuity of care could be interrupted. This should no longer be a problem because OMAP has instituted a weekly health plan enrollment process, and OMAP now requires OHP eligibles to choose a health plan before they are enrolled in OHP.

3.5 Recertification Process

Recertification for the traditional, categorically eligible Medicaid population is conducted as frequently as every month, in conjunction with recertification for other assistance programs. This is the traditional system for Medicaid recertification. The expansion population is recertified every six months. Health plans prefer 6-month recertification for the categorically eligible population also, because they want stable enrollment to minimize adverse selection and administrative expenses. In contrast to this view, OMAP and AFS prefer to recertify categorically eligible OHP members at the same time they recertify them for other assistance programs (usually monthly), because it is more efficient. OMAP and AFS staff feel that monthly recertification for the categorically eligible population should not be a problem for the health plans because eligibility is stable for this population even though they are usually reviewed every month. Those who lose eligibility through traditional Medicaid categories most likely would be covered under the expansion criteria or through transitional Medicaid coverage. Thus, OHP recertification for categorical eligibles continues to be linked to other assistance programs and there are no plans to change to six months.

Recertification at six-month intervals for the expansion population initially was a problem due to the high numbers of enrollees not responding and being disenrolled. A notice is mailed to beneficiaries eight weeks before the end of their certification period telling them that the reapplication package will be mailed soon. The package is mailed six to seven weeks before termination. A second notice is sent four weeks before termination, allowing enough time to request a new application. A termination letter (third notice) is sent three weeks before the end of the certification period (although this is generally too late to

request a new application before termination). In response to concerns from health plans, OMAP now sends mailing labels to health plans each month, for members who are scheduled to terminate that month, so that they can send out their own notices encouraging reapplication. Originally, all expansion beneficiaries received the reapplication packages and notices but now they only go to persons who have not reapplied. Sending the packages to everyone generated unnecessary inquiries to the call center.

Reapplication for the first group of beneficiaries was a particular problem because the number of members coming up for reapplication at the same time was so large and because AFS was just recovering from the unexpectedly heavy initial enrollment. Delays are still encountered whenever the original group of enrollees comes up to a six-month anniversary. In response, AFS opened a new office in Beaverton that handles only reapplications.

Beneficiaries who fail to re-apply in time to prevent termination are dropped from OHP. They can be reinstated retrospectively to avoid breaks in coverage if they established a date of request for an application prior to their termination date. However, their health plan affiliation cannot be reinstated retrospectively, so they return to OHP on a fee-for-service basis for the initial month following recertification, which causes the problem with continuity of care described above.

PCPs also reported that this shifting between capitated and fee-for-service coverage causes significant problems for continuity of care. PCPs reported that beneficiaries initially did not understand the need to reapply and be recertified periodically, but that once they had been through the process, problems diminished. They also reported that denial of claims due to loss of OHP eligibility, changes in health plan enrollment, and changes in PCP affiliation

are common. They have to check all three factors at every visit. This has created enormous administrative burdens for provider staffs. Initially, considerable amounts of time were spent on hold with the State and managed care plans to check eligibility, enrollment, and PCP assignment. An automated information system is now available to verify OHP eligibility and health plan enrollment. Providers still need to contact the plans to verify PCP assignment.

3.6 OHP Eligibility and Enrollment Trends

3.6.1 Aggregate Eligibility Trends

Table 3-1 and Figure 3-1 show trends in the number of OHP eligibles. Phase I eligibility is disaggregated according to current and expansion eligibles. The Phase I OHP population swelled from 197,800 in March 1994 to 329,000 in October 1995 (a 66 percent increase), and then gradually declined to just over 268,000 in August 1997 (an 18 percent reduction).

During this timeframe, the number of current eligibles actually has fallen, and thus, the entire growth in OHP enrollment is attributable to the expansion population. OMAP staff attribute the decrease in current eligibles to an extremely aggressive JOBS program for the AFDC population, which resulted in reduced categorical eligibility, and the shift of some categorically eligible persons to expansion eligibility. This trend may reflect the joint effect of welfare reform and health care reform in decreasing the AFDC rolls in the State.

The OHP expansion population -- comprised of single adults, childless couples, and new families -- grew from 10,700 eligibles in March 1994 (the second month of the program) to nearly 100,000 by December 1994, a growth that exceeded all projections for

Table 3-1

Trends in the Number of Oregon Health Plan Eligibles, By Category of Eligibility, March 1994 – August 1997

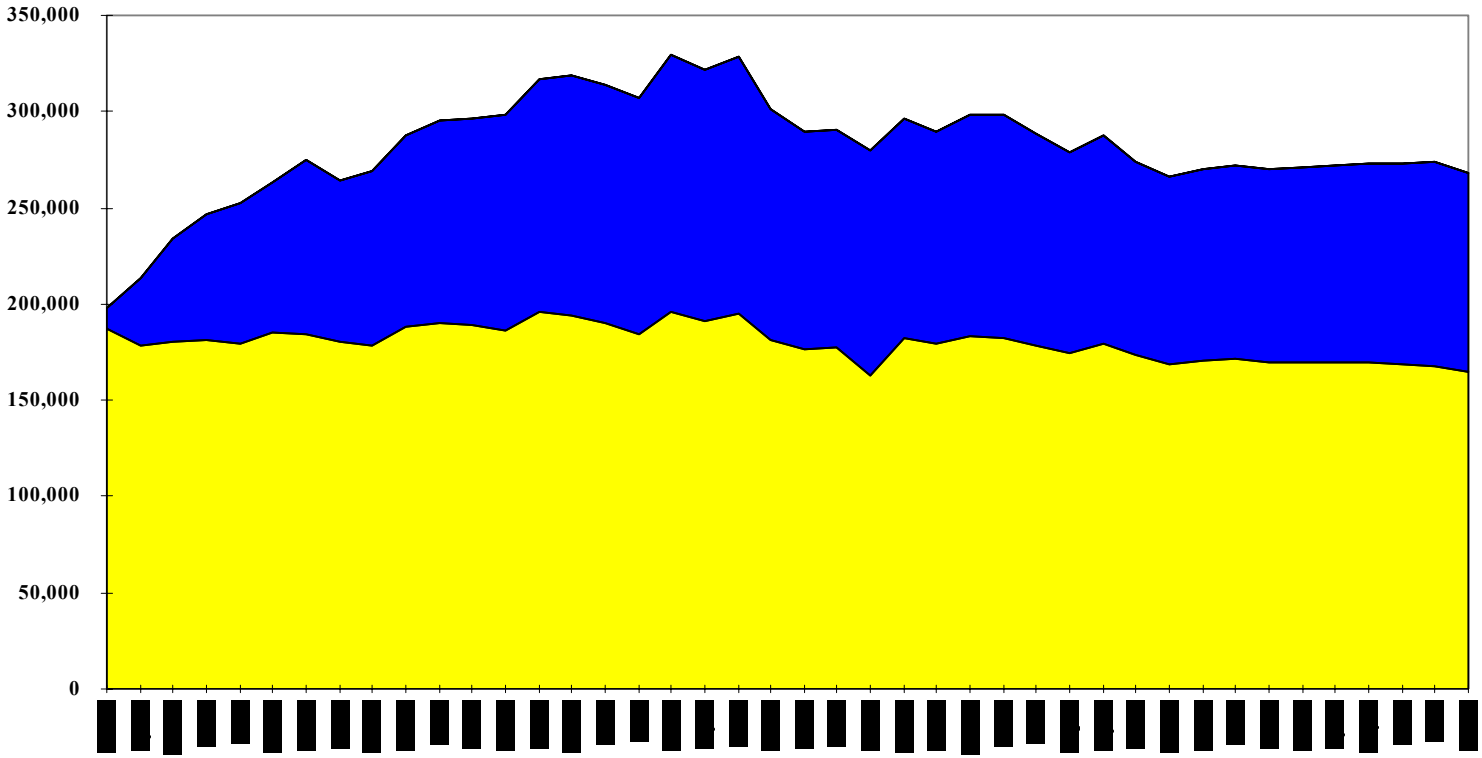
	Month	Total Eligibles	Phase I Eligibles			Phase II Eligibles
			Phase I Subtotal	Current Eligibles	Expansion Eligibles	
1994	March	197,775	197,775	187,068	10,707	0
	April	**213,498**	**213,498**	**178,272**	**35,226**	**0**
	May	234,230	234,230	180,277	53,953	0
	June	**246,374**	**246,374**	**180,979**	**65,395**	**0**
	July	252,894	252,894	179,392	73,502	0
	August	**263,414**	**263,414**	**184,977**	**78,437**	**0**
	September	275,074	275,074	184,237	90,837	0
	October	**263,915**	**263,915**	**180,353**	**83,562**	**0**
	November	268,612	268,612	178,804	89,808	0
	December	**287,830**	**287,830**	**188,368**	**99,462**	**0**
1995	January	295,582	295,582	190,270	105,312	0
	February	**296,834**	**296,834**	**188,762**	**108,072**	**0**
	March	368,740	298,101	185,837	112,264	70,639
	April	**387,879**	**316,579**	**195,902**	**120,677**	**71,300**
	May	390,136	318,455	193,741	124,714	71,681
	June	**385,544**	**313,858**	**189,950**	**123,908**	**71,686**
	July	379,670	307,420	184,152	123,268	72,250
	August	**402,314**	**329,302**	**195,495**	**133,807**	**73,012**
	September	393,722	321,258	190,704	130,554	72,464
	October	**402,703**	**329,008**	**194,830**	**134,178**	**73,695**
	November	375,397	301,609	181,290	120,319	73,788
	December	**364,060**	**289,995**	**176,680**	**113,315**	**74,065**
1996	January	364,688	290,441	177,524	112,917	74,247
	February	**373,794**	**299,521**	**162,688**	**116,833**	**74,273**
	March	370,977	296,798	182,027	114,771	74,179
	April	**364,971**	**289,566**	**178,996**	**110,570**	**75,405**
	May	373,398	298,370	183,399	114,970	75,029
	June	**373,457**	**298,001**	**182,770**	**115,231**	**75,456**
	July	364,635	288,251	178,213	110,038	76,384
	August	**355,553**	**279,078**	**174,379**	**104,699**	**76,475**
	September	363,949	287,678	179,471	108,207	76,271
	October	**351,328**	**274,428**	**173,133**	**101,295**	**76,900**
	November	344,115	266,363	168,603	97,760	77,752
	December	**346,876**	**269,647**	**170,454**	**99,193**	**77,229**
1997	January	349,525	272,015	171,281	100,734	77,510
	February	**347,716**	**270,527**	**170,100**	**100,427**	**77,189**
	March	348,110	271,201	169,983	101,218	76,909
	April	**348,740**	**271,617**	**170,021**	**101,596**	**77,123**
	May	349,973	272,563	169,614	102,949	77,410
	June	**350,343**	**272,716**	**168,780**	**103,936**	**77,627**
	July	351,747	273,964	168,112	105,852	77,783
	August	**346,047**	**268,166**	**164,996**	**103,170**	**77,881**

NOTE: The Phase I population is comprised of two categories. By "current eligibles," we mean Medicaid beneficiaries who were previously eligible for Medicaid prior to the eligibility expansion. By "expansion eligibles," we mean Medicaid beneficiaries who were newly eligible as a result of OHP eligibility expansions.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Monthly Enrollment and Disenrollment Reports, March 1994 - August 1997.

Figure 3-1

Trends In the Number of Phase I Oregon Health Plan Eligibles, By Category of Eligibility, March 1994-August 1997



program enrollment. The number of expansion eligibles continued to grow, peaking at 134,000 in October 1995, when new eligibility criteria were introduced, including an assets test, income averaging over three months, and elimination of full-time students. Further reductions took place following May 1996 when up-to-date premiums were required as a precondition to recertification.

When the Phase II population entered OHP in early 1995, total program enrollment increased from 296,800 to 368,700. Phase II eligibles comprised about 19 percent of the total. As can be seen in Table 3-1, the number of Phase II eligibles has actually increased by 10 percent over the time-series from 70,600 to 77,900.

3.6.2 Distribution by Category of Eligibility

Table 3-2 shows how the distribution of OHP eligibles by category of eligibility has changed over time. Whereas current eligibles comprised 71 percent of the Phase I members in July 1994, the share fell to 61 percent three years later. This reflects a commensurate increase among expansion eligibles. The largest OHP eligibility group still is the AFDC eligibles, although their share has fallen from 49 percent to 30 percent. The share of low-income children increased from 19 percent to 28 percent. General assistance recipients accounted for 1 percent or less of Phase I OHP eligibles.

Meanwhile, among the expansion eligibles, new families comprised a slightly larger percentage of the total than the new adults/couples (20 percent and 18 percent respectively in July 1997). The composition of the expansion eligible population was unexpected. OMAP had projected a higher level of enrollment among single adults and couples than new

Table 3-2

Trends in the Number of Oregon Health Plan Eligibles, by Category of Eligibility

	July 1994		December 1994		July 1995		December 1995		July 1996		December 1996		July 1997	
	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total
Total, Phase I and II eligibles	**252,894**		**287,830**		**379,670**		**364,060**		**364,635**		**346,876**		**351,747**	
Subtotal, Phase I eligibles	**252,894**	**100.0%**	**287,830**	**100.0%**	**307,420**	**100.0%**	**289,995**	**100.0%**	**288,251**	**100.0%**	**269,647**	**100.0%**	**273,964**	**100.0%**
Old-rule eligibles	**179,392**	**70.9%**	**188,368**	**65.4%**	**184,152**	**59.9%**	**176,680**	**60.9%**	**178,213**	**61.8%**	**170,454**	**63.2%**	**168,112**	**61.4%**
AFDC	122,583	48.5%	124,949	43.4%	113,675	37.0%	108,662	37.5%	101,981	35.4%	93,678	34.7%	81,757	29.8%
Pregnant women	5,675	2.2%	6,578	2.3%	6,318	2.1%	6,279	2.2%	6,956	2.4%	7,248	2.7%	7,505	2.7%
Low-income children	48,740	19.3%	54,186	18.8%	61,594	20.0%	59,385	20.5%	67,048	23.3%	67,275	24.9%	76,170	27.8%
General assistance	2,394	0.9%	2,655	0.9%	2,565	0.8%	2,354	0.8%	2,228	0.8%	2,253	0.8%	2,680	1.0%
New-rule eligibles	**73,502**	**29.1%**	**99,462**	**34.6%**	**123,268**	**40.1%**	**113,315**	**39.1%**	**110,038**	**38.2%**	**99,193**	**36.8%**	**105,852**	**38.6%**
New adults/couples	27,447	10.9%	40,015	13.9%	54,793	17.8%	52,235	18.0%	50,849	17.6%	47,170	17.5%	50,495	18.4%
New families	46,055	18.2%	59,447	20.7%	68,475	22.3%	61,080	21.1%	59,189	20.5%	52,023	19.3%	55,357	20.2%
Subtotal, Phase II eligibles					**72,250**	**100.0%**	**74,065**	**100.0%**	**76,384**	**100.0%**	**77,229**	**100.0%**	**77,783**	**100.0%**
Aged					24,771	34.3%	25,287	34.1%	25,925	33.9%	26,364	34.1%	26,307	33.8%
Blind/Disabled					38,573	53.4%	39,702	53.6%	41,210	54.0%	41,416	53.6%	41,304	53.1%
Children in foster care					8,906	12.3%	9,076	12.3%	9,249	12.1%	9,449	12.2%	10,172	13.1%

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Monthly Enrollment and Disenrollment Reports, Selected Months.

families, based on demographic characteristics of the uninsured population. Nevertheless, new adults/couples was the fastest-growing eligibility category, with an 84 percent growth over the three-year period.

Phase II enrollees consist of three groups: the aged (34 percent in July 1997); the blind and disabled (53 percent); and children in substitute care (13 percent), which includes, for example, foster care and subsidized adoption (Table 3-2). Between July 1995 and July 1997, children in substitute care had a larger growth in OHP enrollment (14.2 percent) than either the blind/disabled (7.1 percent) or the aged (6.2 percent).

3.6.3 Special Studies about the Expansion Eligibles

The State has conducted special studies about the new Medicaid eligibles as part of a Quality Control (QC) demonstration project (Oregon Department of Human Resources, 1995a). Based on a sample of 450 cases in the expanded Medicaid group, the State found that about 49 percent had incomes less than or equal to 50 percent of the Federal poverty level (including 30 percent who reportedly had zero income in the initial month), another 45 percent had incomes from 51 to 100 percent of FPL, while the remaining 6 percent of cases apparently were above the allowed income threshold.

Eighty-seven percent of the expanded Medicaid group in the QC sample lived in Oregon for at least one year prior to applying for OHP. Only 2.4 percent had moved to Oregon in the 90-day period prior to submitting the OHP application (Oregon Department of Human Resources, 1995a). In contrast, 21 percent of AFDC applicants moved to Oregon within two months of their application (Oregon Department of Human Resources, 1994a). DHR interviewed State workers who reported that most new residents relocate to Oregon

to follow the crops, to escape violence and gang activities in California, to participate in the Oregon JOBS program, or to obtain employment. The review did not provide any evidence that people moved to Oregon to enroll in OHP.

The QC evaluation also examined whether people dropped their private health insurance coverage either before or after they enrolled in OHP (Oregon Department of Human Resources, 1994b). About 6 percent had insurance at the time of the review, either through employment, an absent parent, or other source. Another 2 percent had insurance prior to receiving OHP, but did not have insurance at the time of the review, mostly because employment had ended or divorce had occurred. The review also elicited information about consumer knowledge: 24 percent of respondents indicated they knew that a household can have health insurance and also be eligible for OHP; 18 percent knew that Oregon can help an individual pay for private health insurance.

The reduction in AFDC eligibles within OHP is especially noteworthy. AFDC eligibles numbered 125,900 in July 1994, and 102,000 two years later (recall Table 3-2). The decrease in OHP eligibility among AFDC recipients prompted the State to undertake an analysis to determine the impact of the OHP eligibility expansion on AFDC caseloads (Oregon Department of Human Resources, 1995b). The hypothesis is that AFDC eligibles will find a job and leave AFDC if they can retain their Medicaid coverage under OHP. The study included three telephone surveys of beneficiaries, intake studies of new AFDC applicants and new OHP applicants, and analysis of AFDC trends in Oregon and other States. According to DHR, none of the analyses provided conclusive evidence that OHP contributed to declines in the AFDC caseload. However, OMAP staff continue to believe there is a correlation between the AFDC reductions and the implementation of OHP.

3.6.4 Health Plan Enrollment and Assignment

Table 3-3 displays trends in managed care enrollment at six-month intervals from July 1994 (the sixth month of the program) through July 1997. The rate of enrollment in a fully or partially capitated health plan grew steadily from 75 percent in July 1994 to 82 percent in December 1996 (including the Phase II population), and leveled off at this rate through the remainder of the time period. Enrollment with a primary care case manager (PCCM) accounted for a small additional share (2.4 percent in July 1997), indicating that few formal exemptions from prepaid health plan enrollment have been granted.

Despite the intent to enroll all OHP eligibles in prepaid health plans, over 55,000 OHP eligibles were not enrolled in some form of managed care as of July 1997. OMAP believes the FFS group is composed of eligibles in transition to health plans, and people who are unassigned because they failed to choose a health plan. They also note that some local case workers who believe their clients are better served by the FFS system may have been less active in enrolling their clients in health plans.

The share remaining in fee-for-service has declined over time, from 24 percent in July 1994 to 16 percent in July 1997, due in part to more aggressive efforts to enroll eligibles in managed care, coupled with greater managed care capacity. OMAP performed auto assignment into health plans in cases where there was only a single health plan in the county, or where a health plan contract was terminated and the enrollee failed to choose another health plan. Additionally, OMAP began to enroll OHP eligibles into managed care on a weekly, rather than a monthly, basis beginning January 1, 1997. The goal was to limit the transition period between the initial eligibility determination and managed care enrollment. Their goal is to achieve 87 percent enrollment in managed care.

Table 3-3

Trends in the Number of Oregon Health Plan Eligibles Enrolled In Managed Care

	July 1994		December 1994		July 1995		December 1995		July 1996		December 1996		July 1997	
	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total	Number of Eligibles	Percent of Total
Total	**252,894**	**100.0%**	**287,830**	**100.0%**	**379,670**	**100.0%**	**364,060**	**100.0%**	**364,635**	**100.0%**	**346,876**	**100.0%**	**351,747**	**100.0%**
Subtotal, Managed Care Enrollment	**192,528**	**76.1**	**227,028**	**76.8**	**308,450**	**81.2**	**308,791**	**84.8**	**309,272**	**84.8**	**294,192**	**84.8**	**296,623**	**84.3**
Prepaid health plans	188,957	74.7	220,429	74.6	295,687	77.9	298,515	82.0	300,184	82.3	285,801	82.4	288,150	81.9
Primary care case management	3,571	1.4	6,599	2.2	12,763	3.4	10,276	2.8	9,088	2.5	8,391	2.4	8,473	2.4
Subtotal, Fee-for-service	**60,366**	**23.9**	**60,802**	**23.2**	**71,220**	**18.8**	**55,269**	**15.2**	**55,363**	**15.2**	**52,684**	**13.0**	**55,124**	**15.7**

NOTE: Beginning in July 1995, figures include the Phase II population.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Monthly Enrollment and Disenrollment Reports, Selected Months.

3.6.5 Health Plan Disenrollment Rates

Several health plans are experiencing more rapid disenrollment than they had expected. They are concerned about the administrative expenses they incur from turnover, and the potential for adverse selection. The health plans attribute this higher-than-expected disenrollment to loss of OHP eligibility due to: (1) the instability generated by monthly recertification of categorically-eligible beneficiaries; and (2) the failure of large numbers of newly-eligible beneficiaries to reapply at the scheduled six-month recertification. They believe that some beneficiaries fail to apply for recertification if they are not ill at the time they are scheduled for recertification and then reapply when they next need health care.

As shown in Table 3-4, the disenrollment rate due to loss of eligibility has fluctuated between a low of 4.1 percent in July 1994 (before the six-month recertifications began) to as high as 8.5 percent in July 1995. The disenrollment rate, for all reasons combined, was 10 percent in two of the six periods shown in Table 3-4, indicating that one in every ten managed care enrollee left their health plan in a given month. Although the health plans believe that this rate is high, OMAP staff believe that it is consistent with turnover in AFDC eligibility.

As noted previously, OMAP and AFS staff presented a different view of the consequences of 6-month recertification for the expansion population. Although both the State and health plans would agree that excessive disenrollment increases administrative expense and the potential for adverse selection, the State believes that the level of disenrollment experienced as a result of 6-month recertification is not high enough to create these problems, yet the health plans believe that it is problematic.

Table 3-4

Trends in the Rate of Disenrollment From Prepaid Health Plans (PHPs)

	July 1994	December 1994	July 1995	December 1995	July 1996	December 1996	July 1997
Total PHP disenrollment (all reasons)	6.3%	7.6%	10.6%	11.6%	8.9%	9.1%	8.6%
Disenrollment due to loss of eligibility	4.1%	5.8%	8.5%	8.0%	7.5%	7.2%	7.7%

NOTE: Beginning in July 1995, figures include the Phase II population. New poverty level thresholds were introduced in July 1995. Eligibility criteria were modified as of October 1, 1995. Premiums went into effect December 1, 1995. See text for details.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Monthly Enrollment and Disenrollment Reports, Selected Months.

The disenrollment rates due to ineligibility reported in Table 3-4 reflect OHP ineligibility; they do not include persons who became ineligible for a health plan because they moved from its service area. Beginning in 1996, OHP ineligibility has accounted for about 85 percent of total enrollments.

It is not possible to determine from the standard disenrollment reports the extent to which disenrollment due to ineligibility is attributable to monthly recertification, failure to apply for 6-month recertification, the imposition of premiums, or other factors. The question may be too subtle to address with statistics in any case since there may be other explanations for why disenrollment rates would differ between the categories recertified monthly and those recertified every six months. Nevertheless, obtaining disenrollment data by reason and eligibility category might help explain the impact of the two recertification strategies. This issue will be addressed in a future report.

3.7 Consumer Scorecard Project

The Office of the Health Plan Administrator (OHPA) was directed, in SB 5530, Oregon Statutes of 1993, to develop a proposal to assist OHP consumers in selecting a health care provider or a health plan. In response, the OHPA facilitated the creation of the Oregon Consumer Scorecard Consortium. The Oregon Health Policy Institute (OHPI), a member of the Consortium, was awarded a contract from the Agency for Health Care Policy and Research (through the University of Washington Rural Health Research Center) to develop a prototype health plan performance scorecard for use by OHP beneficiaries when selecting a health plan.

Currently, OHP beneficiaries receive a county-specific comparison chart that compares each health plan available to county residents on a variety of structural measures, such as covered services. A scorecard would include process and outcome performance measures for each health plan, computed with a standard methodology, that would enable beneficiaries to make a judgment about which health plan performs best relative to the beneficiary's personal preferences.

The scorecard project has conducted focus groups about what information beneficiaries want to have and can use effectively and how best to present it. They tentatively have settled on a combination of statistical performance measures and consumer satisfaction survey measures, which is typical of the trend in report card development. In January 1996, OMAP conducted a satisfaction survey of 18,000 health plan members and OHPI used those data to develop the initial prototype. OMAP modified the survey instrument to accommodate OHPI's data needs by adding health status and access questions.

Following completion of the AHCPR contract in 1996, OHPA and OHPI organized a meeting of public and private sector benefits managers and state and national leaders in health plan performance measurement to decide on future long term strategy for the development of the Oregon scorecard. The meeting, held on January 31, 1997, resulted in a plan to proceed with the development of a standard survey and scorecards for the public and private sector organizations that implement the survey, under the general direction of OHPA. The OHPA is currently organizing a group of health care purchasers, including OMAP, several large employers, and a small employer purchasing cooperative to implement a health plan assessment survey in Spring 1998. They have decided to implement the survey developed by the Consumer Assessments of Health Plan Study (CAHPS), which is funded by AHCPR. It is very likely that this project will be one of the 1998 CAHPS demonstration and evaluation sites.

If OMAP participates in the CAHPS demonstration, as expected, it will use the CAHPS prototype report. This report does not currently include provisions for data from sources other than CAHPS. Thus, OMAP will have to decide, with the assistance of the CAHPS consortium, whether or not to include records-based performance measures in addition to the survey assessments. Other unanswered questions for OMAP include: (1) whether performance charts should be county-specific and, if so, should the data for multi-county health plans be computed at the county-level or statewide; (2) how often should data be updated; and (3) whether separate data should be provided for children's experiences and for chronically ill beneficiaries or persons who use high levels of service. These are typical questions faced by all report card projects.

4 Managed Care Plan Contracts and Financial Status

Oregon's Medicaid managed care experience dates back to 1985 under a 1915(b) freedom of choice waiver. At the time of the Section 1115 waiver application (August 1991), the State contracted with 16 health plans, which served 65,320 Medicaid eligibles, representing about 55 percent of the AFDC population. The State and health plans credit their extensive experience with managed care for the smooth transition to OHP. A core group of health plans already had experience with the Medicaid population and existing reimbursement arrangements with hospitals and physicians.

The State used the interval between the Phase I waiver submission and waiver approval to build the delivery system. The State issued an RFA for prepaid health plans in November 1991, requesting letters of intent from prospective health plans interested in participating in the Oregon Health Plan. The State left the RFA open until the waiver was approved (March 1993). State officials were struck by the profound changes in capacity brought about by the RFA, and provider interest in gaining a share of the Medicaid market. Moreover, new health plans were created just for OHP. The State undertook a review of each plan's policies and procedures, with the aid of a multidisciplinary review panel comprised of experts in public health, managed care, health policy, and medicine. During this interval, the State provided a considerable amount of technical assistance to plans.

This chapter describes the characteristics of managed care plans serving OHP enrollees as of July 1996. The analysis documents the diffusion of Medicaid managed care in Oregon and shows prepaid health plan market shares over time. At the same time that managed care diffused virtually statewide, the level of concentration among the top-five plans increased as well, although the trend has reversed more recently with the growth of local plans. The chapter also discusses rating and selection issues, provider payment arrangements, and utilization review and quality assurance mechanisms. This information was obtained primarily through interviews with State and health plan staff. Finally, this chapter analyzes the financial experience of OHP managed care plans, based on quarterly financial data provided by the plans to the State. This analysis documents a slight loss among all health plans in the aggregate.

4.1 Overview of OHP Prepaid Health Plans

When the Oregon Health Plan began in February 1994, the delivery system included 16 fully capitated health plans (FCHPs), 4 partially capitated health plans known as physician care organizations (PCOs), and 5 dental care organizations (DCOs). Moreover, 317 primary care case managers (PCCMs) had been recruited by the end of March 1994, with capacity to serve nearly 85,000 OHP eligibles. Prepaid health plans were available in all but eight of Oregon's 36 counties (Gilliam, Lincoln, Sherman, Morrow, Tillamook, Lake, Grant and Wheeler). PCCM enrollment was mandatory in these eight counties.

As shown in Table 4-1, 11 of the 20 plans participating at the beginning of OHP had prior experience as a Medicaid managed care contractor under the 1915(b) waiver. Most of

the remaining plans were developed in response to OHP. CareOregon, for example, is a joint venture of the Multnomah County Health Department, the Oregon Health Sciences University (OHSU), and Federally-qualified health centers (FQHCs) around the State. CareOregon providers historically served indigent patients (both Medicaid recipients and uninsured), and the plan was developed to provide continuity of care to its traditional client base.

Another OHP start-up plan, Roseburg Health Enterprises, Inc. (RHEI), now known as SureCare, was developed by the local IPA. The IPA previously had subcontracted with managed care plans for commercial accounts. RHEI was developed by the IPA to contract directly with the State for OHP clients (rather than as a subcontractor with another plan). Two of the new plans that joined OHP in late-1995 followed Roseburg's model, with their local IPAs contracting directly for OHP clients.

As of July 1996, the majority of plans served OHP clients only, and hence were regulated and monitored by OMAP alone. The eight plans that served non-OHP clients in addition are licensed and regulated by the State's Division of Insurance and are termed Health Service Contractors (HSC).

The most common type of plan is a "clinic-based" model (11 plans), in which one or more clinics and/or group practices accept risk (either on a fully- or partially-capitated basis) as a managed care organization. Columbia Managed Care, for example, included three medical groups from the Portland Metropolitan area in close alliance with a local hospital. A hospital is the driving force behind Tuality HealthCare as well.

Table 4-1

Overview of Prepaid Health Plans Participating in the Oregon Health Plan as of July 1996

	OHP Start Date	OHP Termination Date	Prior 1915(b) Waiver Provider	Serving OHP Population Only		Medicare Risk/Cost Contractor	OHP Contractual Arrangement	Type of Plan	Number of Counties Served(1)
CareOregon	**2/1/94**		**N**	**Y**		**---**	**FCHP**	**Clinic**	**13**
Cascade Comprehensive Care (2)	2/1/94		Y	Y		---	PCO-FCHP-PCO-FCHP Conversion	Clinic	1
Central Oregon Independent Health Services	**10/1/95**		**N**	**Y**		**---**	**FCHP**	**IPA**	**7**
Columbia Managed Care	2/1/94	1/31/95	N	Y		---	FCHP	Clinic	N/A
Coordinated Healthcare Network	**2/1/94**	**3/31/96**	**N**	**Y**		**---**	**FCHP**	**Clinic**	**N/A**
Evergreen Medical Systems	2/1/94		Y	Y		---	FCHP	Clinic	2
FamilyCare	**2/1/94**		**Y**	**Y**		**---**	**FCHP**	**Clinic**	**10**
Good Health Plan	2/1/94		Y	N		R	FCHP	Open panel, HSC	6
HMO Oregon	**2/1/94**		**Y**	**N**		**R/C**	**FCHP**	**Open panel, HSC**	**24**
InterCommunity Health Network	3/1/94		N	Y		---	FCHP	Clinic	2
Kaiser Permanente	**2/1/94**		**Y**	**N**		**R**	**FCHP**	**Closed panel, HSC**	**9**
Medford Clinic (3)	2/1/94	9/30/1996	Y	N		---	PCO	Clinic	1
Mid-Rogue Valley IPA	**11/1/95**		**N**	**Y**		**---**	**FCHP**	**IPA**	**2**
ODS Health Plan	3/1/94		N	N		---	FCHP	Open panel, HSC	14
Oregon Health Management Services (4)	**2/1/94**		**Y**	**N**		**---**	**PCO-FCHP Conversion**	**Clinic**	**2**
PACC Health Plan	2/1/94	9/30/1996	Y	N		C	FCHP	Open panel, HSC	3
PacifiCare of Oregon	**2/1/94**	**9/30/96**	**Y**	**N**		**---**	**FCHP**	**Open panel, HSC**	**5**
PrimeCare	2/1/94	6/30/95	Y	Y		---	PCO	Clinic	N/A
QualMed	**3/1/94**	**8/1/1996**	**N**	**N**		**---**	**FCHP**	**Open panel, HSC**	**7**
RHEI Health Plan (SureCare)	3/1/94		N	Y	5	---	FCHP	IPA, HSC	1
SelectCare	**2/1/94**		**Y**	**N**		**R**	**FCHP**	**Open panel, HSC**	**1**
Tuality Healthcare	2/1/94		Y	Y		---	FCHP	Clinic	1

(1) As of July 1996. Oregon has 36 counties.
(2) Formerly known as Klamath Comprehensive Care.
(3) Formerly known as Grants Pass Management Services.
(4) Medford Clinic was taken over by Oregon Health Management Services in October 1996.
(5) RHEI began as an OHP only plan, but subsequently entered into commercial contracts as well.

Second in terms of frequency -- but largest in membership -- are the open panel plans (7 plans), in which the prepaid health plan recruits primary care and specialty providers to join its network and may or may not pass risk on to providers. Kaiser Permanente is the only closed-panel plan within OHP. Another approach is an IPA model comprised of physician practices within a circumscribed geographic area (3 plans).

4.2 Diffusion of Medicaid Managed Care in Oregon

OHP continues to give impetus to the development of managed care throughout the State. Through a combination of service area expansions, new plan developments and PCO-to-FCHP conversions, just two counties (Gilliam and Tillamook) remain without an FCHP. OMAP doubts that Tillamook County, located on the coast just west of Portland, will have a managed care plan. The major Medicaid providers in this county are FQHCs or rural health centers; the health centers have a financial incentive to continue with the existing cost-based, fee-for-service arrangement. HMO Oregon briefly expanded its service area into Gilliam County but withdrew shortly thereafter due to inadequate provider capacity. OMAP continues to require mandatory PCCM enrollment in Gilliam and Tillamook counties, but is no longer attempting to promote capitated managed care plans in the two counties.

Early in the Phase I implementation, managed care plans expressed considerable interest in expanding their service areas, especially to the eight counties with no prepaid managed care presence. However, contracts were not modified until October 1995, due primarily to the OMAP staff focus on dental access problems and the challenges of

integrating Phase II populations into OHP. Subsequently, health plan service areas have been quite dynamic, with the entry and exit of health plans.

Two new FCHPs were developed -- Central Oregon Independent Health Services (COIHS) in central Oregon and Mid-Rogue Valley IPA in southern Oregon. In both instances, the local provider community, following the RHEI model, organized to gain local control and eliminate the "middleman." In particular, they were dissatisfied with the lack of financial reporting and data provided under their former contract with HMO Oregon. OMAP referred to this trend as the "regionalization" of OHP. Neither of these plans in the first instance was expected to expand capacity because, in general, there was a direct shift of enrollees from one plan to another or from a PCO to an FCHP. However, COIHS did expand capitated managed care into one county that previously had none. It is too soon to tell whether these local plans will be fiscally viable and will meet OMAP's performance standards (e.g., submission of encounter data, quality of care audits). Future reports will follow up on the status of regional plans.

In 1995, OMAP notified the four PCOs that the State would no longer be issuing partial capitation contracts after October 1996. Two of the PCOs converted to FCHPs and two closed, transferring their members to existing FCHPs. PrimeCare, Inc., a PCO in Jackson County, ceased operations on June 30, 1995, and its nearly 7,000 OHP enrollees were assumed by HMO Oregon. The Medford Clinic, a PCO with 5,000 enrollees, did not renew its contract on September 30, 1996. Apparently, the plan did not want to become an FCHP. The plan's enrollment was transferred to Grants Pass, which became known as Oregon Health Management Services when it converted to an FCHP. Klamath

Comprehensive Care, which became known as Cascade Comprehensive Care, initially converted from a PCO to FCHP and then converted back to a PCO one month later. In October 1996, the plan formally converted to an FCHP. As of October 1996, there were no PCO contracts remaining; OMAP achieved its goal of expanding fully-capitated managed care and eliminating partial capitation contracts.

The second and third years of OHP also witnessed a number of FCHP closures. Effective January 31, 1995, Columbia Managed Care, a small FCHP in Multnomah County, closed, and its enrollment was assumed by QualMed. QualMed discontinued its OHP contract effective August 1, 1996, due to small membership and high administrative costs. PacifiCare withdrew from OHP at the end of September 1996. Among other reasons was a desire to shift their attention to the Medicare market. Also effective September 30, 1996, PACC Health Plan terminated its OHP contract. The plan was looking for a buyer to capitalize its expansion plans into Eastern Oregon. When the acquisition agreement fell through, the plan opted to withdraw from OHP. The PACC contract was assumed by CareOregon.

OMAP has continued to build PCCM capacity; the aggregate PCCM capacity was projected to be ten times larger than PCCM enrollment. As of December 1994, 6,000 OHP eligibles (2.1 percent) had chosen PCCMs, either because they were in areas not served by prepaid health plans, because they had other third-party insurance, or because they had a health condition that could not be well-served in an existing managed care plan. By July 1996, 9,000 OHP eligibles (2.5 percent) were served by PCCMs. OMAP staff believe that

a spillover effect of the PCCM recruitment efforts has been to increase physician participation in Medicaid more generally.

The status of Medicaid managed care in Oregon, by county, is depicted in Table 4-2 (December 1994) and Table 4-3 (July 1996). Managed care enrollment is disaggregated by type of prepaid health plan (FCHP and PCO) as well as by PCCM. The rate of PHP enrollment increased from 77 percent in December 1994 to 82 percent in July 1996, while the total managed care enrollment rate (including PCCM) went from 79 percent to 85 percent. The rate of increase varied considerably by county. Taking, for example, the six counties that gained prepaid health plan coverage as of October 1995, three achieved sizable PHP enrollments by July 1996 (Grant, 86%; Lake, 79%; and Lincoln, 75%), while the other three had more modest penetration rates (Morrow, 30%; Sherman, 52%; and Wheeler, 31%). When PCCM enrollment is included, the rates in the latter three counties were substantially higher, especially in Sherman County, where total managed care enrollment was 74 percent. Other counties with significant gains in PHP enrollment from December 1994 to July 1996 were Clatsop (rising from 68% to 84%), Hood River (61% to 82%), Malheur (71% to 86%), Umatilla (61% to 73%), and Wasco (58% to 76%).

The diffusion is displayed visually in Figures 4-1 and 4-2, where we can see the increase in number and geographic dispersion of counties with at least 84 percent of their OHP eligibles enrolled in prepaid health plans (black shading). This level was achieved in only three counties in December 1994 (Figure 4-1) versus 14 counties in July 1996 (Figure 4-2). Counties in Eastern Oregon were among the biggest gainers, as existing plans expanded their service areas. By July 1996, only seven counties had less than 70 percent of

Table 4-2

Managed Care Enrollment by County, December 1994

				Managed Care Enrollment						
					Prepaid Health Plan Enrollment					
County	Prior 1915(b) Waiver Status	Number of Plans	Number of Eligibles	Total Managed Care Enrollment	Total Prepaid Health Plan Enrollment	FCHP	PCO	PCCM	Percent of Eligibles Enrolled in Managed Care	Percent of Eligibles Enrolled in PHPs
Total	17 (a)	20 (b)	287,830	226,506	220,429	202,447	17,982	6,077	78.7 %	76.6 %
Baker	--	1	1,918	1,391	1,369	1,369	0	22	72.5	71.4
Benton	M	6	4,463	3,435	3,410	3,410	0	25	77.0	76.4
Clackamas	M	11	16,193	13,424	13,409	13,409	0	15	82.9	82.8
Clatsop	--	4	3,136	2,144	2,132	2,132	0	12	68.4	68.0
Columbia	V	4	2,738	2,058	2,044	2,044	0	14	75.2	74.7
Coos	--	3	8,533	6,514	6,497	6,497	0	17	76.3	76.1
Crook	M	1	1,413	1,061	1,042	1,042	0	19	75.1	73.7
Curry	--	1	2,592	2,240	2,223	2,223	0	17	86.4	85.8
Deschutes	V	1	6,609	5,370	5,336	5,336	0	34	81.3	80.7
Douglas	--	2	13,096	11,061	11,041	11,041	0	20	84.5	84.3
Gilliam	--	0	97	61	0	0	0	61	62.9	0.0
Grant	--	0	715	221	0	0	0	221	30.9	0.0
Harney	M	1	724	607	601	601	0	6	83.8	83.0
Hood River	--	2	1,787	1,114	1,095	1,095	0	19	62.3	61.3
Jackson	M	7	17,139	14,081	14,046	4,544	9,502	35	82.2	82.0
Jefferson	M	1	1,990	1,143	1,113	1,113	0	30	57.4	55.9
Josephine	M	3	11,539	8,861	8,632	4,761	3,871	229	76.8	74.8
Klamath	M	3	7,788	5,620	5,569	960	4,609	51	72.2	71.5
Lake	--	0	946	526	0	0	0	526	55.6	0.0
Lane	M	5	30,397	24,548	24,493	24,493	0	55	80.8	80.6
Lincoln	--	0	5,023	2,707	0	0	0	2,707	53.9	0.0
Linn	M	5	10,308	8,348	8,318	8,318	0	30	81.0	80.7
Malheur	--	2	4,216	3,040	2,987	2,987	0	53	72.1	70.8
Marion	M	6	27,218	22,231	22,189	22,189	0	42	81.7	81.5
Morrow	--	0	1,008	311	0	0	0	311	30.9	0.0
Multnomah	M	12	63,334	52,518	52,487	52,487	0	31	82.9	82.9
Polk	M	6	4,522	3,702	3,696	3,696	0	6	81.9	81.7
Sherman	--	0	282	55	0	0	0	55	19.5	0.0
Tillamook	--	0	2,326	1,127	0	0	0	1,127	48.5	0.0
Umatilla	--	3	6,565	4,058	3,977	3,977	0	81	61.8	60.6
Union	--	3	2,627	1,976	1,937	1,937	0	39	75.2	73.7
Wallowa	--	2	610	491	489	489	0	0	80.5	80.2
Wasco	--	2	1,971	1,142	1,138	1,138	0	4	57.9	57.7
Washington	M	11	17,818	14,548	14,532	14,532	0	16	81.6	81.6
Wheeler	--	0	145	95	0	0	0	95	65.5	0.0
Yamhill	M	6	6,044	4,679	4,627	4,627	0	52	77.4	76.6

FCHP = Fully capitated health plan.
PCO = Physician care organization.
PCCM = Primary care case management.

(a) Number of counties with mandatory (M) or voluntary (V) enrollment in managed care under the 1915(b) waiver prior to OHP.
(b) Represents the unduplicated number of prepaid health plans, including FCHPs and PCOs.

Table 4-3

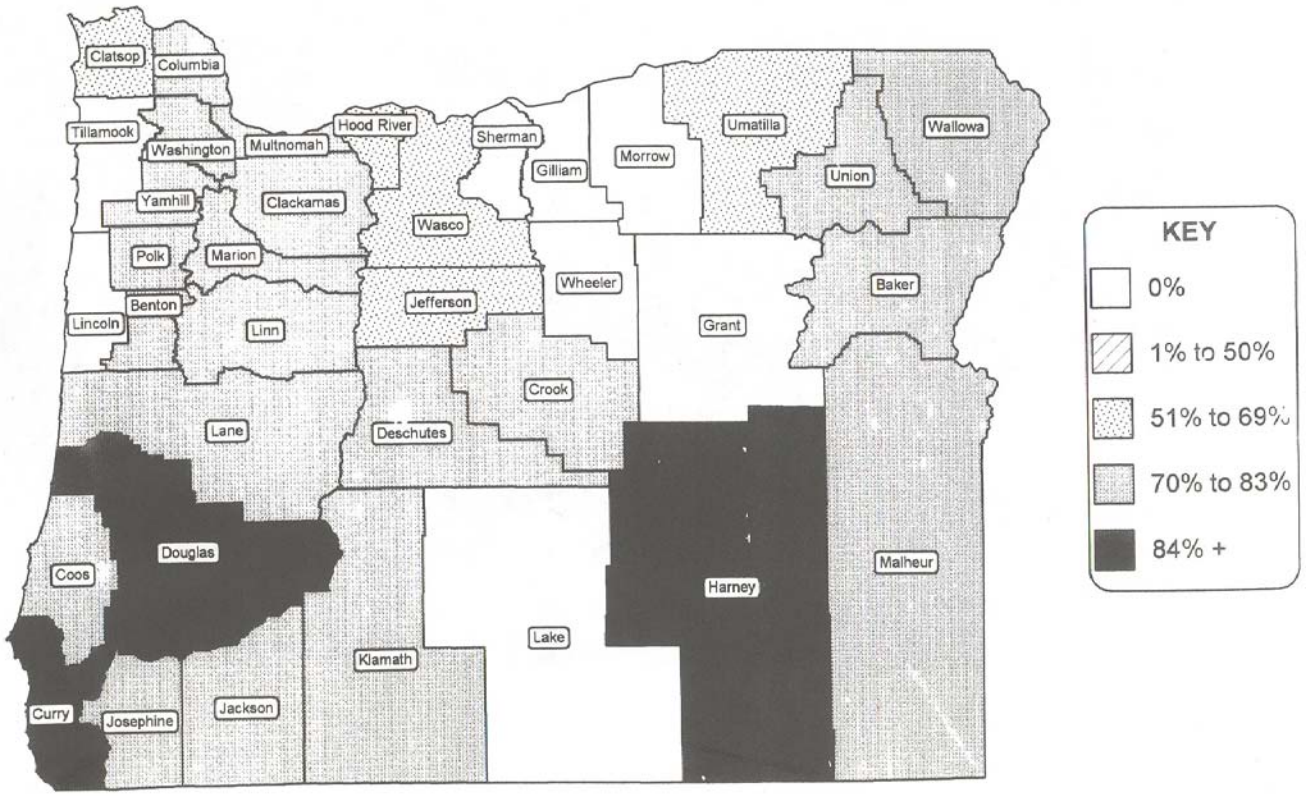
Managed Care Enrollment by County, July 1996

County	Number of Plans	Number of Eligibles	Managed Care Enrollment: Total Managed Care Enrollment	Managed Care Enrollment: Prepaid Health Plan Enrollment: Total Prepaid Health Plan Enrollment	Managed Care Enrollment: Prepaid Health Plan Enrollment: FCHP	Managed Care Enrollment: Prepaid Health Plan Enrollment: PCO	Managed Care Enrollment: PCCM	Percent of Eligibles Enrolled in Managed Care	Percent of Eligibles Enrolled in PHPs
Total	19 (a)	364,635	309,272	300,184	289,614	10,570	9,088	84.8 %	82.3 %
Baker	1	2,492	1,141	990	990	0	151	45.8	39.7
Benton	6	4,855	3,955	3,821	3,821	0	134	81.5	78.7
Clackamas	10	20,379	17,066	16,865	16,865	0	201	83.7	82.8
Clatsop	4	3,884	3,302	3,250	3,250	0	52	85.0	83.7
Columbia	2	3,510	2,938	2,882	2,882	0	56	83.7	82.1
Coos	1	10,150	9,160	9,055	9,050	5	105	90.2	89.2
Crook	1	1,932	1,650	1,630	1,630	0	20	85.4	84.4
Curry	1	2,953	2,700	2,435	2,435	0	265	91.4	82.5
Deschutes	1	9,008	7,842	7,797	7,797	0	45	87.1	86.6
Douglas	2	14,870	13,384	13,323	13,323	0	61	90.0	89.6
Gilliam	0	166	81	0	0	0	81	48.8	0.0
Grant	1	1,111	989	950	950	0	39	89.0	85.5
Harney	1	1,048	970	958	958	0	12	92.6	91.4
Hood River	2	2,515	2,110	2,057	2,057	0	53	83.9	81.8
Jackson	9	21,963	19,331	18,789	13,663	5,126	542	88.0	85.5
Jefferson	1	2,482	1,631	1,605	1,605	0	26	65.7	64.7
Josephine	4	13,882	11,485	10,972	10,965	7	513	82.7	79.0
Klamath	3	8,925	7,074	6,885	1,453	5,432	189	79.3	77.1
Lake	1	1,148	1,027	912	912	0	115	89.5	79.4
Lane	4	37,854	32,342	31,658	31,658	0	684	85.4	83.6
Lincoln	1	6,115	5,104	4,597	4,597	0	507	83.5	75.2
Linn	5	12,195	10,295	9,998	9,998	0	297	84.4	82.0
Malheur	2	5,306	4,674	4,541	4,541	0	133	88.1	85.6
Marion	5	34,901	29,943	29,653	29,653	0	290	85.8	85.0
Morrow	2	1,306	704	394	394	0	310	53.9	30.2
Multnomah	9	85,294	73,467	72,018	72,018	0	1,449	86.1	84.4
Polk	5	5,824	4,967	4,910	4,910	0	57	85.3	84.3
Sherman	1	246	181	127	127	0	54	73.6	51.6
Tillamook	0	2,727	1,904	0	0	0	1,904	69.8	0.0
Umatilla	3	7,933	5,875	5,761	5,761	0	114	74.1	72.6
Union	3	3,267	2,750	2,583	2,583	0	167	84.2	79.1
Wallowa	2	901	819	805	805	0	14	90.9	89.3
Wasco	2	2,817	2,218	2,152	2,152	0	66	78.7	76.4
Washington	9	23,151	19,983	19,777	19,777	0	206	86.3	85.4
Wheeler	2	187	126	58	58	0	68	67.4	31.0
Yamhill	6	7,338	6,084	5,976	5,976	0	108	82.9	81.4

FCHP = Fully capitated health plan.
PCO = Physician care organization.
PCCM = Primary care case management.

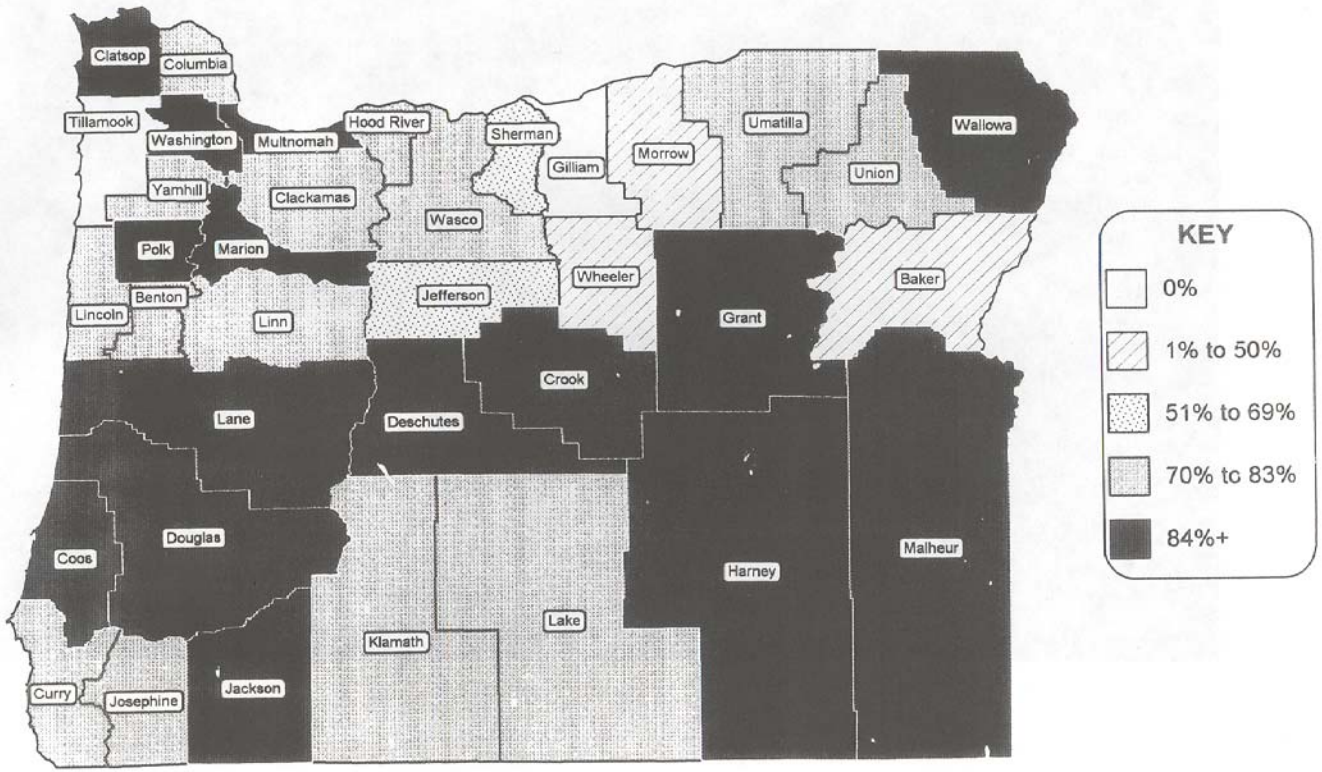
(a) Represents the unduplicated number of prepaid health plans, including FCHPs and PCOs.

Figure 4-1
Percent Enrolled in Prepaid Health Plans, by County, December 1994



4-11

Figure 4-2
Percent Enrolled in Prepaid Health Plans, by County, July 1996



4-12

their OHP eligibles enrolled in PHPs. These counties were located predominantly in the North Central section of the State.

4.3 Market Shares of Prepaid Health Plans

Table 4-4 shows the statewide market shares of FCHPs and PCOs at five different time intervals. The time-series extends to July 1997 to show the impact of plan closures and start-ups on the distribution of OHP enrollees. In December 1994, nearing the end of the first year of OHP, 220,000 OHP eligibles were enrolled in the 20 prepaid health plans (including 18 FCHPs and 2 PCOs). HMO Oregon, the Blue Cross & Blue Shield HMO, had 37 percent of OHP enrollment. The next two largest health plans, CareOregon and Kaiser, had 9 percent each. Another two plans -- ODS Health Plan and SelectCare -- enrolled 5 percent or more. These five largest plans accounted for two-thirds of OHP enrollees in managed care plans. With a cumulative enrollment of just 9 percent, the eight smallest plans enrolled less than 2 percent each. Four of these plans enrolled less than 1 percent.

The level of concentration increased over time, with the top five plans accounting for over 70 percent of the OHP market in December 1995, and nearly 73 percent in July 1996. In December 1995, HMO Oregon alone enrolled 41 percent of OHP members, climbing to nearly 43 percent as of July 1996. The number of plans declined to 19 as of July 1996 (a net reduction of one plan over the two-year period).

We expected the level of concentration to increase further with the closure of several plans in August and September of 1996 (PacifiCare, PACC, and QualMed).

Table 4-4

Trends in Managed Care Enrollment by Health Plan

	July 1994		January 1995		July 1995		January 1996	
	Number of enrollees	PHP Market Share	Number of enrollees	PHP Market Share	Number of enrollees	PHP Market Share	Number of enrollees	PHP Market Share
Total OHP eligibles	**252,894**		**295,582**		**379,670**		**364,688**	
Total PHP enrollees	**188,957**	**100.0%**	**228,488**	**100.0%**	**295,687**	**100.0%**	**293,345**	**100.0%**
Percent enrolled in PHPs	74.7%		77.3%		77.9%		80.4%	
CareOregon	16,951	9.0%	19,693	8.6%	25,288	8.6%	23,879	8.1%
Cascade Comprehensive Care[a]	4,503	2.4%	4,839	2.1%	5,818	2.0%	5,376	1.8%
Central Oregon IHS	0	0.0%	0	0.0%	0	0.0%	1,420	0.5%
Columbia Managed Care	264	0.1%	759	0.3%	0	0.0%	0	0.0%
Coordinated HealthCare Network	713	0.4%	1,123	0.5%	1,729	0.6%	1,505	0.5%
Evergreen Medical Systems	1,781	0.9%	2,032	0.9%	1,681	0.6%	1,770	0.6%
FamilyCare	7,278	3.9%	9,302	4.1%	9,224	3.1%	10,292	3.5%
Good Health Plan	5,648	3.0%	9,647	4.2%	16,651	5.6%	17,842	6.1%
HMO Oregon	71,771	38.0%	85,847	37.6%	123,809	41.9%	121,526	41.4%
Intercommunity Health Network	1,555	0.8%	3,380	1.5%	5,845	2.0%	6,274	2.1%
Kaiser Permanente	17,765	9.4%	19,579	8.6%	17,960	6.1%	18,805	6.4%
Medford Clinic*	3,584	1.9%	4,205	1.8%	5,412	1.8%	5,132	1.7%
Mid-Rogue IPA	0	0.0%	0	0.0%	0	0.0%	3,796	1.3%
ODS Health Plan	13,062	6.9%	15,378	6.7%	25,610	8.7%	25,360	8.6%
Oregon Health Management Services	3,744	2.0%	3,990	1.7%	4,042	1.4%	3,734	1.3%
PACC Health Plan	4,156	2.2%	5,316	2.3%	6,574	2.2%	4,068	1.4%
PacifiCare	7,633	4.0%	10,039	4.4%	13,350	4.5%	11,529	3.9%
PrimeCare	4,585	2.4%	5,432	2.4%	0	0.0%	0	0.0%
QualMed	2,498	1.3%	3,175	1.4%	1,942	0.7%	1,775	0.6%
RHEI Health Plan	8,989	4.8%	10,467	4.6%	12,892	4.4%	12,067	4.1%
SelectCare	11,301	6.0%	12,817	5.6%	15,683	5.3%	14,977	5.1%
Tuality Health Care	1,176	0.6%	1,468	0.6%	2,177	0.7%	2,218	0.8%

Table 4-4 (continued)

Trends in Managed Care Enrollment by Health Plan

	July 1996		January 1997		July 1997	
	Number of enrollees	PHP Market Share	Number of enrollees	PHP Market Share	Number of enrollees	PHP Market Share
Total OHP eligibles	**364,635**		**349,525**		**351,747**	
Total PHP enrollees	**300,184**	**100.0%**	**293,525**	**100.0%**	**288,150**	**100.0%**
Percent enrolled in PHPs	82.3%		84.0%		81.9%	
CareOregon	24,635	8.2%	27,430	9.3%	26,326	9.1%
Cascade Comprehensive Care[a]	5,432	1.8%	5,396	1.8%	5,756	2.0%
Central Oregon IHS	1,887	0.6%	13,889	4.7%	19,191	6.7%
Columbia Managed Care	0	0.0%	0	0.0%	0	0.0%
Coordinated HealthCare Network	0	0.0%	0	0.0%	0	0.0%
Evergreen Medical Systems	1,692	0.6%	1,796	0.6%	1,363	0.5%
FamilyCare	10,790	3.6%	11,093	3.8%	12,854	4.5%
Good Health Plan	19,920	6.6%	22,534	7.7%	23,718	8.2%
HMO Oregon	127,809	42.6%	105,377	35.9%	95,603	33.2%
Intercommunity Health Network	7,167	2.4%	11,135	3.8%	10,629	3.7%
Kaiser Permanente	19,476	6.5%	20,303	6.9%	19,871	6.9%
Medford Clinic*	5,138	1.7%	0	0.0%	0	0.0%
Mid-Rogue IPA	4,059	1.4%	4,115	1.4%	4,443	1.5%
ODS Health Plan	25,760	8.6%	35,504	12.1%	34,186	11.9%
Oregon Health Management Services	3,969	1.3%	9,202	3.1%	9,640	3.3%
PACC Health Plan	3,310	1.1%	0	0.0%	0	0.0%
PacifiCare	10,035	3.3%	0	0.0%	0	0.0%
PrimeCare	0	0.0%	0	0.0%	0	0.0%
QualMed	1,629	0.5%	0	0.0%	0	0.0%
RHEI Health Plan	12,439	4.1%	11,343	3.9%	11,044	3.8%
SelectCare	12,801	4.3%	12,310	4.2%	11,570	4.0%
Tuality Health Care	2,236	0.7%	2,098	0.7%	1,956	0.7%

[a]Klamath Comprehensive Care became Cascade Comprehensive Care in November 1995.

[b]Grants Pass Health Services changed its name in September 1996 to Oregon Health Management Services.
Oregon Health Management Services took over Medford Clinic in October 1996.

However, this was not found to be the case. HMO Oregon's statewide market share dropped to 33 percent as of July 1997 (from 43 percent a year earlier). A new plan, COIHS, grew to 6.7 percent of the OHP enrollment with the expansion of its service area into counties previously served by other plans. Together, the top six plans (each with shares of 5 percent or more) accounted for 66 percent of OHP enrollees. This represents a reduction in the level of concentration over time. This is consistent with the phenomenon of "regionalization" discussed earlier, where the statewide plans are losing dominance while local plans are gaining market share.

4.4 Rating and Selection Issues

One of the objectives behind OHP was to raise Medicaid fees to eliminate cost-shifting of services provided to Medicaid patients onto private payors. Thus, initial capitation rates were based on projected fees that were more generous than the historical fee-for-service rates. Indeed, health plans and providers initially seemed relatively satisfied with the rates. Over time, however, the level of satisfaction has eroded for a number of reasons.

Health plans report that the State has not adjusted rates for changes in the benefit package made following implementation (see Chapter 5). The Health Services Commission and administrative law judges have *de facto* expanded the benefit package, e.g., adding certain transplant benefits. In the past, OMAP had taken the position that rates would not be adjusted until the next biennial revision and repricing of the list,

unless the cost impact of each *individual* change was one percent or more.[1] OMAP noted that the plans were beginning to feel the "financial pinch," and they planned to adjust the rates when the *cumulative* impact exceeded one percent.

Effective October 1, 1995, OMAP reduced the capitation rates paid to managed care plans. In particular, OMAP's actuary, Coopers & Lybrands, "introduced" a 5.5 percent savings for managed care efficiencies. This adjustment for managed care efficiencies was done in lieu of moving to a competitive bidding environment.[2] The majority of health plans indicated a preference for this approach and indicated they would "manage" to that target. The actuarial development (*Analysis of Federal Fiscal Year 1996 & 1997 Average Costs*, February 10, 1995) incorporates the following "adjustments for managed care savings":

- It was assumed that the health plans could save 30 percent on their inpatient and outpatient hospital costs, for most eligibility categories.
- An offsetting 10 percent increase in physician costs was assumed to reflect the anticipated shift of patients from inpatient to ambulatory care settings.
- Maternity costs were assumed to decrease by 10 percent as the managed care plans reduced their C-section rates and improved maternity outcomes through prenatal care.
- Prescription drug costs were assumed to increase by 5 percent as physicians substituted drug therapy for other treatments. However, for the Medicare population, they assumed a 15 percent decrease, since the plans

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[1] The list was initially priced at the beginning of the program (February 1, 1994) and then repriced October 1, 1995. The next repricing will take place October 1, 1997 and every two years thereafter.

[2] OMAP noted that representatives of three health plans participated on an advisory panel which considered options for reducing the OHP budget. Additionally, OMAP indicated the plans were given an opportunity to comment on the proposed eligibility changes, premiums, and priority list changes. Again, managed care "efficiencies" were preferred to competitive bidding.

would have significant incentive to control the costs of drug therapy in this high use population.

The rate reductions were not well received by the plans, and several plans were deeply concerned that the reductions would have an adverse impact on provider participation. The exit of several commercial plans in 1996 was in part a "cumulative" response to concerns about the financial impact of the rate reduction.

The plans also complained that the initial administrative cost allowance of only 6 percent was unreasonable. HMO administrative cost ratios typically run 10 to 12 percent or more. Also, several plans asserted that the initial actuarial development was defective in its allocation of costs by benefit category. One plan had overpaid its hospital pool in the first year based on the Coopers & Lybrands development. Another plan reported that the prescription drug benefit had not been adequately budgeted.

Another rate reduction took place on January 1, 1996. In principle, the reduction was to be self-financing, through a reduction in benefits (i.e., upward movement of the priority line). The plans, however, seemed skeptical that the projected savings could be realized. Based on experience to date, they doubted that services falling below the line could actually be denied to the extent assumed in the actuarial estimates. In plans paying providers on a fee-for-service basis, we were told that providers have found ways to bill and get paid for below-the-line services. And capitated providers were providing many of the services anyway.

Several plans complained of adverse selection and OMAP's unwillingness to either "carve out" expensive care or otherwise recognize it in the rates. For example,

CareOregon told us that they have 45 percent of the AIDS patients in the State. Yet their capitated rates are the same as any other plan. Moreover, one-third of their patients do not speak English, compared to an average of just 6.5 percent in other plans.

Both CareOregon and QualMed believed that they had received a disproportionate share of high risk pregnancy and transplant patients, due to their affiliation with OHSU. QualMed believed that high risk mothers had simply been assigned to their plan.[3] In some instances, the mothers would transfer to another plan after having the child. PACC likewise informed us that certain case workers had decided that PACC had one of the best maternity programs and were signing up all of their pregnant patients with PACC. The State instituted a maternity/newborn risk pool to address disproportionate numbers of deliveries across plans. The State has begun to consider the possibility of risk adjusting the capitation payments to health plans, especially to account for the distribution of AIDS patients.

As part of the evaluation, we plan to address questions related to adverse selection and variations in the risk profile among health plans. However, such analyses will require complete encounter data which are not yet available.

4.5 Provider Payment Arrangements

There is comparatively little uniformity in provider payment arrangements for managed care. Different plans pay quite differently, and the same plan often has

[3] QualMed ultimately withdrew from Multnomah County because of their adverse financial experience, which they attributed to adverse selection.

different payment arrangements with different provider groups. As examples, HMO Oregon typically pays physicians on a modified fee-for-service basis (although they were moving to capitated arrangements); Good Health Plan and CareOregon capitate their primary care physicians and then purchase specialty services on a modified fee-for-service basis; and PacifiCare capitates medical groups for both primary and specialty care. Kaiser, of course, relies on its own salaried medical staff to provide most professional services.

Hospital payment arrangements also vary across health plans. Some plans pay hospitals on a discounted charge basis; others pay on a per diem basis; and at least one plan (RHEI) now pays its hospitals on a fully capitated basis. Moreover, in at least one instance (Lane County), a hospital entity is capitated for both professional and hospital services.

Most plans pay fee-for-service providers on a RBRVS (Resource-Based Relative Value Scale) basis, but the conversion factors vary substantially across plans. HMO Oregon is reputed to be the most generous payer, paying almost $33 per Relative Value Unit in the Portland area. Conversely, CareOregon is perhaps the least generous payer, reporting that they pay $27 per Relative Value Unit. By comparison, Oregon Medicaid uses a conversion factor of $23.75 for traditional payment purposes. The payment rates are believed to vary somewhat by geographic area, but no information on the geographic differences is currently available.

Even plans that pay professionals on a fee-for-service basis invariably include some kind of risk-pooling arrangement. For example, in the first year, HMO Oregon

withheld 10 percent of payments pending an end-of-year settlement. No monies were returned at the end of the first year; and HMO Oregon is now increasing its withhold to 15 percent. The risk pooling arrangements vary enormously across plans.

RHEI and Family Care have "pioneered" in their expanding use of subcapitation. RHEI, for example, began by capitating its primary care providers and executing a single capitated contract for urgent care services. More recently, they have capitated both hospital and laboratory services (both within-office and out-of-office). RHEI chose to broaden capitation, in part, to reduce the capitalization requirement and minimize the stoploss insurance costs associated with fee-for-service risk. The within-office laboratory component, however, was capped due to the excessive billing of some providers.

4.6 Utilization Review and Quality Assurance

OHP quality assurance (QA) mechanisms are multifaceted. The State performs periodic on-site reviews as well as desk audits of prepaid health plan performance. The on-site and off-site reviews focus on the structure and operations of each plan's internal QA component. The State also requires health plans to submit detailed quarterly financial data that are used primarily for the purpose of monitoring financial solvency, profitability, and reserves.

In addition, the State contracts out for an external quality review based on a medical chart audit. The medical record review for the first year of OHP, conducted by the Oregon Medical Peer Review Organization (OMPRO) cited deficiencies in

preventive care practices and eye exams for diabetes. Another chart audit, reflecting performance in the second year of OHP, is underway. Peer Review Systems of Ohio (PRS) is assessing the process of care for asthma, diabetes, and depression, among other conditions. In addition, as part of the evaluation, HER has contracted with PRS for a chart audit of a sample of OHP enrollees with low back pain, a below the line condition. PRS is validating the encounter data against medical records as well.

The State is extremely rigorous in its reviews -- some plans perceive the level of review to be micro-management -- and the State holds health plans to different standards depending on their level of sophistication and maturity. Two plans were sanctioned for inadequate quality review procedures and corrective action was taken. Plan enrollment was closed during the period of corrective action and Phase II enrollment was delayed in these two plans. Ironically, these two plans had longstanding experience with Medicaid beneficiaries under the 1915(b) program. However, their QA infrastructure required modification to ensure quality of care.

To date, OMAP has done no analyses of prepaid health plan performance from OHP encounter data. They are still constructing their initial encounter data file. Also, OMAP has not provided any utilization reports to health plans from its encounter data files.

Anecdotal reports suggest that, in plans which also have commercial business, the quality assurance committees tend to monitor quality on a plan-wide basis, rather than performing special studies on the OHP population separately. Indeed, it is easier to profile providers and reliably discriminate problems if one has a larger population and more data.

4.7 Financial Experience of OHP Managed Care Plans

4.7.1 Introduction

Discussions with OMAP suggested that plan financial performance has been mixed. Most plans are spending more on administrative costs than had originally been planned in the capitation rates. They also observed that the plans paying providers on a capitated basis were doing better than those paying on a fee-for-service basis. OMAP also reported that 10 plans experienced negative margins in the first year. HMO Oregon independently informed us they had lost $3.5 million in the first year and were continuing to lose money. Moreover, one plan (SelectCare) has been deemed to be "impaired" by the Insurance Department for its commercial business. In general, we were told that plan reserve levels are not adequate. OMAP indicated particular concern about the plans with fewer than 5,000 members. They noted, for example, that the medical loss ratio at Grants Pass Clinic has been too high.

To document the financial performance of OHP managed care plans, we undertook an analysis of the plans' annual audited financial statements and quarterly financial statements. This section reviews and analyzes the financial performance of health and dental plans participating in OHP, as represented in the information available to date from OMAP. After discussing the methods and data issues, we present the results for the prepaid health plans and dental care plans separately. Primary emphasis is given to examining the financial experience of health plans. The experience of dental plans receives lesser attention.

4.7.2 Data and Methods

OMAP maintains two separate financial reporting requirements. It requires OHP contractors to provide audited financial statements within six months after the end of each calendar year. In addition, OMAP requires contractors to provide quarterly financial statements, as well as utilization reports, within 60 days after the end of each quarter. Specific formats and detailed definitions are indicated for all reporting requirements.[4] OMAP staff carefully review the reported data, note inconsistencies, and work with the health plans to reconcile discrepancies.

This analysis is based on the quarterly financial and utilization reports, in electronic format, for the first seven quarters of OHP activity, beginning with the first quarter of 1994 and continuing through the third quarter of 1995. Although all plans are represented in this data, for all quarters contracted, the quality and completeness of reporting varies enormously across plans. We have also received the 1994 audited financial statements for all but one health plan and all but one dental plan operating in that year.[5]

The audited financial statements, in principle, should be the more dependable source of plan financial information. Unfortunately, the audited statements are generally less useful for evaluating OHP financial experience. OMAP does not require that the audited income statement report revenue and expense on an OHP-specific basis. In 1994, just nine of the 20 OHP-participating health plans provided services only to OHP members. For these plans, accounting for only a fifth of total OHP premiums paid, the audited income statements fairly

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[4] See "Solvency Plan and Financial Reporting," OMAP, October 1, 1995.

[5] Audited financial statements were not provided for either the Medford Clinic or Multicare Dental.

depict OHP experience.[6] For the other 11 plans, however, many of which have large commercial groups, the audited statements report revenue and expense only on a consolidated, corporate basis and it is not possible to distinguish OHP-specific experience.

In their quarterly reports, plans are required to report experience on an OHP-specific basis. Although no guidance is provided on allocating overhead costs across product lines, these quarterly reports, if prepared correctly and consistently, should fairly depict the OHP-specific revenues, expenses and profitability of each plan on a quarterly basis. As we shall see, however, the reports are not always prepared correctly and consistently.

For most plans, the quarterly financial reports indicate extraordinary volatility in financial results from quarter to quarter.[7] The variances are simply too large to be attributable to differential operational results; and we can only surmise that they arise due to reporting difficulties or accounting idiosyncrasies. For this reason, we shall focus on evaluating each plan's cumulative financial experience under OHP, aggregating experience over the entire seven-quarter interval for which we have information. To the extent that revenues and expenses are simply misreported by quarter, such aggregation should mitigate comparability problems.

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[6] For many plans, the audited income statements do not conform to OMAP requirements, and the information provided is not consistently reported. Nevertheless, with the exception of Tuality Health Alliance and CareOregon, the information reported from the audited statements tracks reasonably well with quarterly financial reports.

[7] Although not evaluated for this report, the quarterly utilization reports also indicate similar instability or inconsistency.

4.7.3 Financial Performance of Prepaid Health Plans

Table 4-5 reports the cumulative financial results for calendar year 1994 through the third quarter of 1995, for all 20 health plans participating in OHP during that interval, including the now defunct Columbia Managed Care. As seen from this table, the aggregate OHP premiums paid to these plans amounted to $542 million. HMO Oregon, with $223 million in premiums, accounted for 41 percent of the total.

As reported by the health plans themselves, ten of the 20 plans were profitable and ten were not. Aggregate net income ranged from a $1.4 million loss for HMO Oregon to a $1.8 million gain for the Medford Clinic. Moreover, the percent net income (or profit margin) ranged from -12 percent for both Coordinated Healthcare Network and QualMed to +45 percent for the Medford Clinic.[8] In total, however, the plans reported that they lost half a million dollars on OHP, for an aggregate average profit margin of -0.1 percent. That is, the quarterly financial reports imply that the health plans basically broke even on OHP *in the aggregate*.

The reported administrative ratios also varied markedly, ranging from 4.5 percent for ODS Health Plan to more than 20 percent for both Grants Pass Clinic and Coordinated Healthcare Network.[9] The average aggregate administrative ratio, based on plan reported spending, was 9.0 percent.

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[8] Columbia Managed Care (now defunct) reported a profit margin of -26 percent.

[9] While still in business, Columbia Managed Care had an administrative ratio of 50 percent.

Table 4-5

Cumulative Financial Results on OHP Line of Business, January 1, 1994 Through September 30, 1995, by Plan

					In Percent		
	Total Revenue	Administrative Expense	Medical Expense	Net Income	Administrative Ratio	Medical Loss Ratio	Profit Margin
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
'repaid Health Plan							
CareOregon	**$47,588,109**	**$5,553,197**	**$41,597,319**	**$437,593**	**11.67**	**87.41**	**0.92**
Columbia Managed Care	188,776	94,841	144,095	-50,160	50.24	76.33	-26.57
Coordinated Healthcare Network	**2,469,729**	**520,505**	**2,257,086**	**-307,862**	**21.08**	**91.39**	**-12.47**
Evergreen Medical Systems	4,842,337	311,571	4,321,766	209,000	6.43	89.25	4.32
FamilyCare	**17,816,257**	**1,740,538**	**15,538,680**	**537,039**	**9.77**	**87.22**	**3.01**
Good Health Plan	30,134,017	3,727,722	27,230,052	-823,757	12.37	90.36	-2.73
Grants Pass Clinic	**4,535,803**	**1,055,556**	**2,722,746**	**757,501**	**23.27**	**60.03**	**16.70**
HMO Oregon	225,947,143	19,030,744	208,353,381	-1,436,982	8.42	92.21	-0.64
InterCommunity Health Network	**8,621,526**	**591,127**	**7,784,226**	**246,173**	**6.86**	**90.29**	**2.86**
Kaiser Permanente	40,284,870	2,156,580	38,910,886	-782,596	5.35	96.59	-1.94
Klamath Comprehensive Care	**4,681,410**	**640,403**	**3,744,022**	**296,985**	**13.68**	**79.98**	**6.34**
Medford Clinic	4,130,661	533,695	1,750,192	1,846,774	12.92	42.37	44.71
ODS Health Plans	**44,594,167**	**1,991,506**	**42,715,587**	**-112,926**	**4.47**	**95.79**	**-0.25**
PACC Health Plan	16,038,927	1,717,928	15,211,875	-890,876	10.71	94.84	-5.55
PacifiCare of Oregon	**26,257,109**	**2,100,931**	**25,415,421**	**-1,259,243**	**8.00**	**96.79**	**-4.80**
Prime Care	3,399,234	479,514	2,818,921	100,799	14.11	82.93	2.97
QualMed	**6,389,889**	**1,172,490**	**5,969,095**	**-751,696**	**18.35**	**93.41**	**-11.76**
RHEI Health Plan	23,445,632	3,577,061	19,095,594	772,977	15.26	81.45	3.30
SelectCare	**30,808,115**	**1,986,108**	**28,704,902**	**117,105**	**6.45**	**93.17**	**0.38**
Tuality Healthcare	4,073,791	325,425	3,143,256	605,110	7.99	77.16	14.85
TOTAL	**546,247,502**	**49,307,442**	**497,429,102**	**-489,042**	**9.03**	**91.06**	**-0.09**
)ental Care Organization							
Capitol Dental Care	**16,258,899**	**1,610,587**	**12,670,401**	**1,977,911**	**9.91**	**77.93**	**12.17**
Hayden Family Dentistry	2,744	303	1,285	1,156	11.04	46.83	42.13
Managed Dental Care of Oregon	**6,797,963**	**507,654**	**6,218,864**	**71,445**	**7.47**	**91.48**	**1.05**
Multicare Dental	3,778,191	969,211	2,975,839	-166,859	25.65	78.76	-4.42
Oregon Dental Service	**16,443,279**	**940,984**	**17,835,620**	**-2,333,325**	**5.72**	**108.47**	**-14.19**
Roseburg Dental Service	1,275,456	248,168	938,946	88,342	19.46	73.62	6.93
Willamette Dental Group	**1,622,721**	**393,567**	**972,629**	**256,525**	**24.25**	**59.94**	**15.81**
TOTAL	**46,179,253**	**4,670,474**	**41,613,584**	**-104,805**	**10.11**	**90.11**	**-0.23**

OTES: Administrative Ratio = col. (2)/col. (1); Medical Loss Ratio = col. (3)/col. (1); Profit Margin = col. (4)/col. (1).

OURCE: Prepaid Health Plan Quarterly Financial Solvency Reports, Seven Quarters (1/1/94-9/30/95), original analysis by Health Economics Research, Inc.

Although the audited financial statements are inadequate or incomplete in some respects, they are nevertheless helpful in understanding and interpreting the quarterly-reported information. In particular, reported costs may be understated, inconsistent, or incomplete:

- InterCommunity Health Network states: "Members provide certain services to the Network without charge. These services include occupancy expenses and salaries and benefits for certain employees who perform services on behalf of the Network."

- The audit report for Klamath Comprehensive Care states that "incurred but not reported" (IBNR) claims are not reflected in the financial statements.

- The auditors for Grants Pass Clinic note that the statements were prepared on a cash basis, which would mean that IBNR claims are excluded.

- CareOregon's audit report notes that "the County also funded certain expenses." Moreover, the 1994 income statement reports a loss of $360,000 whereas the quarterly reports indicate a $151,000 gain.

- The quarterly reports and audited financial statement for Tuality Health Alliance are inconsistent. The 1994 audited income statement reflects the cost of stoploss insurance, whereas the quarterly reports for 1994 do not.

- Reporting is incomplete for the Medford Clinic. Until the third quarter of 1995, its quarterly reports included no physician service expense.

If these six health plans with demonstrable reporting problems (InterCommunity, Klamath, Grants Pass, CareOregon, Tuality and the Medford Clinic) are excluded, the average profit margin on OHP business drops from -0.1 percent to -1.0 percent, and we have nine of 14 plans losing money on OHP over the seven-quarter interval. The average administrative ratio reported for this 14-plan subset is 8.6 percent, largely unchanged from that reported for all 20 plans.

Another concern is that administrative costs seemingly are understated in the quarterly reports of some plans:

- SelectCare improbably reports negative administrative expense in the first quarter of 1995.

- PacifiCare's administrative expense drops from $551,000 in the fourth quarter of 1994 to $50,000 in the first quarter of 1995. Compensation and occupancy expense are both reported as being "0" for the first three quarters of 1995.

Moreover, in meeting with the plans, we were told consistently that OHP members are more costly than commercial members. Yet the quarterly reports indicate that the plans' OHP administrative ratios are dramatically lower than the overall administrative ratios indicated from the audited income statement.

- HMO Oregon's overall 1994 administrative ratio is 11.6 percent, compared to a quarterly reported administrative ratio of 8.4 percent for OHP.

- PacifiCare's overall 1994 administrative ratio is 11.9 percent, compared to a quarterly reported average of 8.0 percent.

- SelectCare's overall 1994 administrative ratio is 11.0 percent, compared to a quarterly reported average of 6.4 percent.

- ODS Health Plan's overall 1994 administrative ratio is 10.3 percent, compared to a quarterly reported average of 4.5 percent.

One possible explanation for the higher plan-wide administrative costs is the inclusion of corporate marketing costs. OHP does not allow direct marketing to beneficiaries, substantially reducing OHP administrative expenses.

On balance, we think it unlikely that anyone was actually administering OHP for less than 11 percent.[10] If one makes this hypothetical assumption and considers

[10] Health plans should not incur marketing expense for their OHP line of business due to the prohibition on direct marketing to beneficiaries. Marketing accounts for a fifth or less of total administrative expense for HMO Oregon and PacifiCare, the only two plans that report it on their audited income statement.

that the administrative cost ratio was actually 11 percent for all plans reporting a lesser percentage, the average profit margin in the 17 plans without other apparent reporting problems (i.e., excluding only the Medford Clinic, Grants Pass and Klamath) is -2.9 percent, implying a net loss of $15 million.[11] Moreover, the overall average administrative ratio is 11.1 percent. Excluding Kaiser, whose staff-type administrative arrangements are not really comparable to those of the other health plans, the average administrative ratio increases modestly to 11.5 percent. However, this may not be unreasonable during the start-up period, especially among new OHP-only plans.

The results above suggest that the contracting health plans have incurred losses on OHP business. The concept and measurement of "profit margin," nevertheless, can be highly ambiguous for health plans that share risk with their providers. In its 1994 audited income statement, for example, Evergreen Medical Systems reported an accrual of provider incentives equal to 17.5 percent of its OHP revenues. If these incentives had not been paid, Evergreen's 1994 reported gain of 5.3 percent would have been transformed into a gain of 22.8 percent. Other health plans also reported paying substantial provider incentives in 1994: CareOregon, 10.0 percent; SelectCare, 13.7 percent; and PacifiCare, 8.0 percent. Several other plans reported paying lesser incentives, e.g., 1.6 percent for both RHEI and HMO Oregon.

Provider incentives, however, were not consistently reported. Many plans did not report any provider incentives, positive or negative. In most instances, one would

[11] Our results suggest that the smaller, provider-owned or dominated health plans have done somewhat better than the larger, commercial HMOs. Due to our concerns about inconsistent reporting, however, we are reluctant to indicate any strong inferences at this time.

expect to see some amount reported. CareOregon reported provider incentives in all four of its 1994 quarterly reports, but it reported no incentives in any of its 1995 quarterly reports. Kaiser Permanente reported extraordinary expense in the fourth quarter of 1994, more than doubling its administrative ratio. This possibly reflects the payment of year-end provider bonuses, but we cannot confirm this from the information provided.

When significant incentives are being paid to providers, it is difficult to know if those incentives should actually be accounted as costs. In a provider-owned health plan, for example, corporate income taxes can be avoided by distributing "profits" as provider incentives or bonuses. Moreover, other health plans could be making unduly generous distributions to their providers in order to avoid the appearance of earning large profits on OHP business.

One cannot determine easily whether provider incentives should be accounted as "costs" or "profits." This can only be done through careful review of the incentive arrangements included in OHP provider contracts. Moreover, we would like to establish whether OHP incentive arrangements were specified in advance, and then compare those arrangements to: (1) arrangements for other lines of business (if any) within the same health plan, and (2) the provider arrangements in competing plans. Unfortunately, the requisite information on provider incentive arrangements is not available from OHP.[12]

[12] Although all model provider contracts must be approved by OHP, the contracts submitted for OHP review do not include attachments describing payment rates and incentives.

4.7.4 Financial Performance of Dental Care Organizations

We were told by OMAP that DCO financial performance falls at "both ends of the spectrum." Capitol Dental Care, in particular, reportedly had incurred significant losses. Willamette Dental, on the other hand, was said to be doing comparatively well.

Based on our analysis, the financial performance of OHP dental plans is indeed highly variable. The average reported profit margin on OHP dental business is -0.2 percent, nearly breakeven. However, profit rates vary from a loss of 14.2 percent for Oregon Dental Service to gains of 12.2 percent and 15.8 percent, respectively, for Capitol Dental and Willamette Dental Care.[13,14] The administrative ratio averages 10.1 percent in our data, but plan-specific ratios range from 5.7 percent for Oregon Dental Service to nearly 20 percent or more for three dental plans (Multicare, Roseburg and Willamette). Unlike the administrative expense reporting of health plans, we have no indication that dental plan administrative ratios are understated.[15] The medical loss ratio (i.e., percent of revenues paid to providers) is less than 80 percent for three plans (Capitol Dental, Roseburg and Willamette), and only 60 percent for Willamette Dental.

4.7.5 Implications of Financial Performance Data

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[13] Although Managed Dental Care reports a profit margin of only +1.0 percent, it also reports that it has paid provider incentives equal to 12.4 percent of program revenues. Roseburg Dental Service is the only other dental plan reporting provider incentive payments (equal to 6.4 percent of OHP revenues).

[14] The results for Hayden Family Dentistry should be ignored. It has just begun operations in the last two quarter of our data and had only 28 members in its last quarter.

[15] However, the administrative expense reported by Multicare varies improbably from one quarter to another.

Although some of the financial performance data may be of questionable reliability, the general thrust of the results is that health plans are incurring financial losses on their OHP line of business. Indeed, all but one of the plans that has terminated its contract with OHP has incurred a financial loss.

Plan	OHP Termination Date	Profit Margin
Columbia Managed Care	1/31/95	-26.57
Coordinate Healthcare Network	3/31/96	-12.47
QualMed	8/1/96	-11.76
PACC Health Plan	9/30/96	-5.55
Pacificare	9/30/96	-4.80
PrimeCare	9/30/96	+2.97

Also of concern is the financial status of the top-five plans, which together enrolled 73 percent of OHP members as of July 1996.

Plan	Profit Margin
CareOregon	+0.92*
Good Health Plan	-2.73
HMO Oregon	-0.64
Kaiser Permanente	-1.94
ODS Health Plans	-0.25

* The quarterly financial statements differed from the audited financial statement, which showed a $360,000 loss for 1994 rather than a $151,000 gain.

Our analysis has focused on the first seven quarters of OHP. This period has represented a transition in many ways -- for example, with the expansion of eligibility to those who were previously uninsured; the diffusion of managed care into new areas; the implementation of the priority list; and the enrollment of people with disabilities and the elderly (dual eligibles) into managed care. Both the high administrative costs associated with implementation and possible pent-up demand among new enrollees could account for negative margins during this period. OMAP also suggests that plans will more aggressively manage the covered benefit package. Ongoing monitoring is required to determine longer-term trends.

Another area for future analysis concerns the factors associated with positive versus negative margins -- for example, the mechanism(s) for paying providers, management of the benefit package, and the impact of "regulation" on profitability. Preliminary evidence suggests that plans regulated by the Division of Insurance are more likely to have negative margins than those monitored by OMAP alone.

Whether the number of plans will dwindle further remains to be seen. Several factors suggest this is a likely scenario. First, budget shortfalls at the State level are likely to result in additional cutbacks in managed care capitation rates, further squeezing health plan profitability. Second, upward movement of the priority line may place increased pressures on health plans to pay for uncovered services. Third, there is a feeling that plans have continued to participate in OHP as a "goodwill gesture" to OMAP. Now that Phase II is fully implemented, plans may not feel such an "obligation" to participate.

While a reduction in the number of plans may actually be desirable from an administrative standpoint -- to reduce the administrative costs to the State and to providers -- the obvious concern is whether provider capacity, and hence, access to care, will deteriorate. Moreover, increased concentration of managed care enrollment among fewer health plans may reduce the level of nonprice competition among health plans, and perhaps have a detrimental effect on the quality of care. We will continue to monitor these trends.

5 The Oregon Health Plan Benefit Package

The Oregon Health Plan (OHP) benefit package is based on a prioritized list of health services. The priority list consists of paired conditions and treatments ranked hierarchically from most to least medically necessary or appropriate. Covered services are those above a cut-off line that is determined according to the level of resources available to fund the program. Services "below the line" are uncovered, except in cases where there is a comorbid condition which would qualify for coverage. The priority list is one of the unique features of OHP and the feature which delayed implementation by about two years.

The priority list was intended to assist the State in rationing the services, not the people, that would be covered by the Medicaid program. The theory was that the State could expand insurance coverage to more low-income uninsured people (who were not otherwise categorically eligible for Medicaid) by eliminating coverage for treatments that were not proven effective, or for conditions which improved on their own. The list of covered benefits would be reduced when the State faced a budget shortfall, as opposed to restricting eligibility or cutting provider fees.

Within the State, there is virtually unanimous praise for the list. In fact, the list of covered services is quite extensive, and represents an expansion of benefits received under the traditional Medicaid program (e.g., preventive care for adults, dental care for adults,

hospice care, and transplants for adults), while few services of consequence are being denied. The services provided by OHP include:

- Preventive services to promote health and reduce the risk of illness (e.g., immunizations, well child visits, physical exams for adults, mammograms and pap smears, prenatal care).
- All diagnostic services such as exams, x-rays, laboratory tests.
- All physical and mental health services (in demonstration areas) included in the condition-treatment list of services.[1]
- Comfort care or hospice treatment for all terminal illnesses.
- Ancillary services (prescription drugs, physical therapy, DME) if medically appropriate for a covered condition-treatment pair.

This chapter focuses on the implementation of the list, including the process for refining the list, the development of practice guidelines associated with administering the list, issues involved in implementing the list, and experience with the list to date. Please refer to Appendix A for a brief overview of the origins of the priority list and the process used to develop the list.

[1] Mental health services were included on the Integrated List of Prioritized Health Services in 20 counties, which included approximately 25 percent of the State's population. In the remaining (nondemonstration) counties, mental health benefits were limited to Priority One services for adults (i.e., the Severely and Persistently Mentally Ill who are a danger to themselves or others), and comprehensive benefits for persons under age 21.

5.1 Implementation and Refinement of the Priority List

The priority list is constantly-evolving. Initially, the State found that a lot of conditions and treatments had been omitted from the priority list and that it needed to add them to the existing list. Then, in 1995, the mental health and chemical dependency diagnoses and procedures were integrated into the list. Additionally, guidelines have been developed to assist health plans and providers in administering the list. We begin with a discussion of the role of two commissions – the Health Services Commission and Health Resources Commission – in implementing and refining the list. We then describe the evolution of clinical practice guidelines.

5.1.1 Role of the Health Services Commission

Before the demonstration began, the Health Services Commission (HSC) requested the authority to make technical corrections to the priority list. In 1991, the Oregon Legislature granted the Commission the ability to revise the list under the following circumstances: (a) technical changes due to errors or omissions; and (b) changes due to advancements in medical technology or new data regarding health outcomes. If new funding is required to implement a change, the Commission is required to report to the Emergency Board for funding.

HSC's primary task is to present a new prioritized health services list to the Governor and Legislature in July of the even year prior to the start of a legislative session. Requests for technical corrections to the priority list are sent to the Health Outcomes Subcommittee.

If the Subcommittee recommends the request to HSC for approval, then the fiscal impact would be assessed by the Office of Medical Assistance Programs (OMAP) and the actuary. HSC also can review any line upon request by an individual member of the Commission. Additionally, technical corrections have been requested by the managed care organizations to correct errors and omissions. The Commission sent letters to provider groups in February 1994, asking whether new mortality or cost information should be considered in the refinement of the list. If such new information existed, then the Health Outcomes Subcommittee would apply content-neutral criteria (derived from the community values) for re-assessing the placement of a C-T pair on the list.

In 1994, 40 technical changes were made to the list. The majority of these changes involved adding or deleting CPT-4 or ICD-9 codes which refined the codes to better reflect current medical practice (HSC, 1995). However, one shift in the priority list is particularly worth noting. The public and the medical community did not accept as being below the line the surgical repair of uncomplicated hernias in children. Adverse media publicity occurred within weeks of the program's implementation. Formerly at line 607, this C-T pair was moved to line 6, following the review of new medical information on health outcomes. The fiscal impact of this change was under 0.2 percent of the total capitation. The cumulative effect of all 40 changes was less than 1 percent (HSC, 1995).

During the first year, the Commission added eight new lines to the list (as a result of splitting a previous line into two lines); eleven items were moved from one line to another line; two lines were deleted from the list; and six lines were moved from their original

position (of which, three were moved from below to above the cut-off line).[2] These changes along with the new C-T pairs for mental health and substance abuse treatment were added to the priority list in January 1995. The "Integrated List of Health Services" resulted in a change from 696 items to 745, of which 606 were covered.

In January 1996, the cut-off line was raised 25 items to line 581. This line movement discontinued coverage for chronic bronchitis (line 594), and disorders of function of stomach and other functional digestive disorders (line 595).

Later that year, the Legislative Emergency Board proposed raising the line another eight items (to line 573), to partially address OHP budget shortfalls during the current biennium. In December 1996, HCFA approved movement of the cut-off line only to line 578. Movement of the line above this level would have discontinued coverage of treatment for sexually transmitted diseases.

5.1.2 Role of the Health Resources Commission

The Health Resources Commission (HRC) was created in 1992 to perform research that leads to recommendations to the Governor and Legislature concerning the use, effectiveness and cost of medical technology in the State. The HRC consists of nine

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[2] The following items were moved on the priority list: traumatic amputation of thumb or other finger/replantation, amputation (from line 453 to line 235); sicca syndrome/medical therapy (from line 614 to line 399); episcleritis/medical therapy (from line 643 to line 400); respiratory failure due to primary pulmonary hypertension, primary pulmonary fibrosis, and Eisenmengers disease/heart-lung and lung transplants (from line 494 to line 442); inflammation of lacrimal passages/incision, medical therapy (from line 598 to line 485); and infertility due to anovulation/medical therapy (from line 577 to line 619).

members appointed by the Governor, including four physicians, a representative from each of four industries (hospitals, business, the insurance industry, and organized labor), and one consumer. The Commission maintains a Medical Technology Assessment program (MedTAP) to foster appropriate adoption and diffusion of medical technologies. At any one time, the Commission is involved in assessing two to three technologies, up to about eight to twelve per year.

With respect to the Oregon Health Plan, the HRC has provided the HSC with a set of guidelines for the surgical management of anal fistula/fissures which have been adopted into the priority list. The HSC also has asked the HRC to evaluate cochlear implants, a costly technology which is still considered experimental. To date, OHP has not paid for cochlear implants.

5.1.3 Evolution of Clinical Practice Guidelines

Assessing the Acceptability of Guidelines. In 1993, the Oregon Legislature modified the HSC's charge to include examining the role of clinical practice guidelines in refining the priority list. Uncertain as to the acceptance of such guidelines among health care providers and consumers, the Commission developed two forms of community input. First, a sample of health professionals was surveyed. The survey asked providers whether guidelines were currently in use and if so whether they were used for reimbursement, quality

assurance, peer review, or education. Thirty-six of the 51 respondents[3] (71 percent) stated that guidelines were in use. The majority supported the use of guidelines for educational purposes only.

In addition, five consumer focus group sessions were held around the State, with participants selected at random to reflect the State's demographics. Participants were willing to have providers use clinical guidelines with one important exception. The time allotted for the provider to be with the patient should not be specified. On the basis of the survey and focus groups, the HSC concluded that the use of and need for clinical guidelines was validated.

Framework for the Development of Treatment Guidelines. The HSC defined clinical guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (HSC, 1995). Their purposes were:

- To decrease the variations in clinical practice patterns in order to provide more consistent outcomes, maintain quality, and reduce costs;
- To diminish the uncertainty of quality, effectiveness, and appropriateness of treatment;
- To synthesize the recent changes in scientific knowledge and medical technology;
- To provide needed information that could improve and assist health care decision-making using approaches that are understandable to both providers and patients.

[3] A total of 66 providers were sampled for a response rate of 77 percent.

A proposed guideline must be relevant to one of the lines on the priority list. A guideline could be developed if: (1) it addresses a high-frequency condition; (2) it addresses a high-cost condition; (3) it addresses a condition for which there is high variation in the process of care; or (4) if an external agency or person requests a guideline and provides supporting documentation consistent with the Commission's purpose for using guidelines. An adopted guideline must be implementable and evaluable based on measurable clinical findings or health status indicators. Greater preference will be given to guidelines developed by national sources with assessments of their validity and reliability. No more than eight guidelines can be developed per biennium.

After the identification of a potential guideline, the appropriate specialties will be contacted to provide literature regarding the topic. An expert panel will be appointed to review the guideline and will make a recommendation to HSC. The Commission will accept or reject the guideline, refer the guideline back to the expert panel for revision, or recommend a public hearing be held prior to making a decision. All guidelines will be reviewed no less than once every six years and revised if necessary.

Current Treatment Guidelines. Guidelines serve multiple purposes. In some cases, they are used to define circumstances under which care for a "below-the-line" condition-treatment pair will be provided. In other cases, they are used to define a "standard of care" that is recommended under OHP. In yet another case, guidelines can be used to limit services under the priority list in order to save money.

In October 1994, the Health Services Commission appointed a task force to work on clinical guidelines. Guidelines for repair of adult hernia and management of severe rhinitis were approved in August 1995. The hernia guideline, for example, was added to line 6 (where uncomplicated hernia repair for children was placed when it was separated from adults). The guideline covers uncomplicated hernias in persons over the age of 18 that present with: (1) persistent pain requiring medication, and/or (2) significant risk for strangulation and/or incarceration. In the absence of the guideline, all uncomplicated hernias in adults would be an uncovered service.

Another guideline project was initiated by the Oregon Health Division. The Diabetes Guidelines Advisory Group proposed guidelines for the care of patients with type I and type II diabetes. The Commission reviewed the guidelines at its August 1995 meeting and plans to monitor their implementation by the managed care plans. If the guidelines are demonstrated to be useful, the Commission will discuss an approach for incorporating these guidelines into the priority list. The goal of this guideline is to promote cost-effective practice in a voluntary context. The guideline does not delimit what will or will not be paid for, but rather establishes a "standard of care."

Yet another guideline effort was undertaken by the Medical Directors' Committee. The Committee developed guidelines for preventive care for children as well as treatment for children with special health care needs (e.g., cystic fibrosis and cerebral palsy). These guidelines were especially critical for health plans and providers with limited experience

with the Medicaid population (especially people with disabilities). Again, these guidelines are voluntary, but represent a consensus among health plan medical directors.

In January 1997, the State adopted a guideline for dental benefits to set limits on coverage. In this case, the guideline was seen as a cost-cutting measure. Dental benefits were essentially open-ended, with no limits on coverage for preventive, acute, and restorative care. As discussed in Chapter 8, the guidelines are being used to control utilization. Without such limitations, the State is concerned that the dental benefit will not remain fiscally viable.

5.2 System and Client Safeguards

Several processes are in place to help providers, health plans, and clients navigate, obtain information, and resolve conflicts within OHP. Such safeguards were mandated under HCFA's Special Terms and Conditions.[4] This section describes the mechanisms currently in place to safeguard against inappropriate denial of treatment, including the Benefit Hotline, hearings process, ombudsman service, and exceptional needs care coordination (ENCC). Although the ombudsman and ENCC services were established in response to the special

[4] The Special Terms and Conditions stipulate, "Oregon will adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual has a funded condition that would entitle the individual to treatment under the program. In the case of a condition-treatment pair that is not on the prioritized list of health services or an unfunded condition-treatment pair in association with a comorbidity, where the expected outcome is comparable to that of a funded condition-treatment pair, providers will be instructed to provide the specified treatment. Oregon will provide, thorough a telephone information line and through the applicable appeals process... for expeditious resolution of questions raised by providers and beneficiaries in this regard."

needs of the Phase II population, we highlight these components because they are an integral component of the OHP benefit package from a consumer's perspective.

5.2.1 Benefit Hotline

The State established a Benefit Hotline, staffed by registered nurses, who respond to telephone inquiries regarding the priority list. The nurses provide information about the C-T pairs and assist callers in identifying the proper line to code a service. When the program was implemented, the Benefit RNs also provided training and education concerning ancillary services (especially to physical therapists, laboratories, and equipment suppliers), explained new services (e.g., dental care, hospice, and rehabilitation), authorized coverage for comorbid conditions, and "grandfathered" treatments that were no longer covered. During the first quarter of operations, over 80 percent of the calls concerned proper line placement. By the fourth quarter of 1995, fully 99 percent of questions concerned line placement.

The Benefit Hotline nurses work together and discuss solutions to new issues. Difficult coding issues are brought to the attention of the OMAP medical director. An early problem, for example, was the coding of repair of a tear of the anterior crucial ligament. The only coding for this service was under sprain/strain, which was uncovered. A decision was made to change the location of the code to internal derangement of the knee, a covered line item.

Three nurses originally staffed the Hotline. A fourth nurse has been added to assist in staffing and vacation coverage. Initially they received approximately 80 calls per day, the average call lasting 11-12 minutes. By December 1995, they received 38 calls per day, each lasting 19 minutes on average. Despite the reduced volume of calls, the complexity of the calls has increased. Three-fourths of the calls are answered immediately, the remaining one-fourth are directed to voice mail with a return call made within the hour.

As of December 1995, OMAP had a cumulative total of 20 fee-for-service requests for coverage of comorbid conditions.[5] These are defined as a C-T pair below the funded line that coexists with and is exacerbated by one or more other current and existing C-T pairs that may be above or below the line. Of the 20 requests, 15 were approved. Examples of approved treatments are: treatment of pharyngitis, anal fissure, lesion excision, and upper respiratory infection. Denied treatments include orthodontia and hernia repair. Treatments were denied if the comorbidity was not found to have a detrimental impact on health.

The Benefit Hotline is targeted to the individual fee-for-service practitioner. Physicians who are members of health plans are referred to the benefits director of that health plan. Most of the calls (93%) are from fee-for-service practitioners and the rest from patients or health plans. Some of the smaller plans that do not have the requisite computer systems have utilized the Benefit Hotline to determine what services are covered.

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[5] Statistics are not maintained on handling of comorbidities by the managed care plans.

5.2.2 Hearings

OHP clients may file a complaint or seek a hearing at any time. Members are not required, but are encouraged, to work within their plan's internal grievance process before requesting a hearing. The fee-for-service (FFS) and managed care plan hearings processes had separate administrations until recently.

Fee-for-Service Hearings. FFS hearings can be requested in two ways. The client can talk with the caseworker at the branch office and request Form 443 (Administrative Hearing Request). Alternatively, the client may contact the State directly and request a hearing. In preparing for a hearing, OMAP typically orders medical/payment histories from the claims system (e.g., number of providers, diagnoses, fees paid). Most of the FFS hearings deal with billing rather than medical issues -- for example, where a provider is not aware that the patient is covered by OHP and bills the patient (which is not permitted), or where the provider is aware that the patient is covered by OHP, but does not know how to bill OMAP. Most situations are readily resolved because they are simply a matter of "confusion" on the part of providers; only 7 of 30 recent requests actually ended with hearings, and one was held open for more information.

Managed Care Hearings. When managed care clients receive a letter of denial, the letter is supposed to be accompanied by an explanation of hearing rights, which explains the health plan's complaint and appeals process. After a complaint is filed with the health plan, the plan's QA committee and medical director would gather the medical records and write a letter with conclusions. However, Federal regulations entitle a client to file a hearing

request directly with OMAP (initiated through a case worker), as well as to file a complaint and hearing request simultaneously. They can obtain Form 443 (Administrative Hearing Request) from the plan, branch office, or OMAP.

Hearings must be held within 90 days; about six weeks of research usually is required prior to the hearing. One of the problems with managed care hearings is that providers often are not willing to give the medical records to the plans due to confidentiality concerns. Therefore, OMAP has to contact the providers directly for the medical records.

Most of the managed care hearings have dealt with below-the-line services (Table 5-1). The largest proportion are related to denials of surgeries, including hernias, ganglion cysts, tonsil-and-adenoidectomies. Denial of hernia repair is a common cause for hearings because oftentimes, the client's job depends upon the surgery. However, the decision to deny the service usually is upheld because the service is not covered under OHP. In general, OMAP advises the patients to "be in touch with their bodies." If anything changes (e.g., complications), they should contact a physician immediately. Then the hernia might be covered.

Table 5-2 shows the disposition of closed hearing requests for both the third-quarter 1995 and second-quarter 1996. The patterns are very similar in the two time periods and are representative of other months as well. The plan decided to pay for the treatment in about one-third of the cases (without going through the full hearings process), while in another third the claimant withdrew the case. In about one-fifth of the cases, the hearing decision was in favor of the plan (i.e., affirmed). In the remaining 12-14 percent of cases, the client

Table 5-1
Types of Complaints in Pending Hearing Requests,
as of October 1995 and June 1996

	Number of Pending Hearing Requests	
	October 1995	June 1996
Total	**38**	**42**
Surgery Denials	**16**	**13**
Hernia/spermatocele	5	5
Breast reduction	2	2
Ear reconstruction	1	0
Ganglion cyst	1	0
Great toe/foot reconstruction	2	1
Eye surgery	1	0
Tonsillectomy	2	0
Gastroplasty	1	1
Other surgery (unspecified)	1	4
Other Denials	**14**	**18**
Emergency room visit	6	7
Dental care	4	5
Prescription drugs	1	2
Electric wheelchair/Durable Medical Equipment (DME)	1	2
Physical therapy	0	1
Unspecified refusal of service	2	1
Providers	**4**	**3**
Out-of-plan provider	3	0
Midwife	0	2
Unspecified referral denied	1	1
Miscellaneous Services	**3**	**4**
Weight control	0	1
Sexual device	0	1
Food supplement	0	1
Cochlear implants	1	0
Pain therapy	1	1
Treatment of hepatitis	1	0
Miscellaneous Problems	**1**	**4**
Complications of care	0	1
Disenrollment	1	1
Access	0	2

SOURCE: OMAP Hearing Requests Log.

Table 5-2

Disposition of Closed Hearing Requests, Third Quarter 1995 and Second Quarter 1996

Disposition of Closed Hearing Requests	Third Quarter 1995 Number	Third Quarter 1995 Percent	Second Quarter 1996 Number	Second Quarter 1996 Percent
Total	**58**	**100%**	**100**	**100%**
Plan will pay	19	33	35	35
Claimant withdrew	19	33	31	31
Claim affirmed	13	22	22	22
No show	3	5	6	6
Claim reversed	3	5	2	2
Agency withdrew	1	2	0	0
Dismissed	0	0	3	3
Written off by provider	0	0	1	1

did not show for the hearing, the agency withdrew, the case was dismissed, or the service was written off by the provider.

A number of interventions, such as training and negotiation, increased the resolution of requests prior to the scheduled hearing. Certain plans seemed to be "denying and then investigating." At first, OMAP was assisting the plans by identifying comorbidities, but now the plans are being much more proactive.

The State does not distinguish Phase I from Phase II eligibles in tracking hearing requests. However, they report that the most common hearings surrounding the Phase II population seem to be in DME and ancillary services. An especially contested area seems to be related to wheelchairs.

5.2.3 Ombudsman

Ombudsman services were mandated as part of Phase II implementation by Senate Bill 5530. The ombudsman serves as a client's advocate to resolve client concerns about access to, quality of, or limitations on the care being provided. The ombudsman responds to individual health care complaints, researches the facts surrounding the complaint, communicates with all parties involved, and attempts to resolve the problem. Throughout the process, the ombudsman is an advocate for the client and represents the client's best interests in resolving the problem. Although specifically set up for the Phase II population, the ombudsman does not distinguish between Phase I and Phase II clients in accepting and handling complaints.

Initial intake of complaints is via a toll-free telephone line. Concerns are triaged into two categories based on urgency. The majority of complaints are questions that are easily answered or handled with a phone call. Complaints that are not easily and immediately resolved become "cases" that are handled by the ombudsman. The two most common complaints in 1996 were related to billing and specialty care issues (e.g., referrals). Other frequent complaints included: access to dental services, DME, and pharmacy.

As shown in Figure 5-1, the number of cases has held relatively steady during the seven quarters, averaging about 216 per quarter. However, the number of other calls peaked in the fourth quarter and then dropped sharply. The surge in calls is attributable to placing the telephone number for the ombudsman's office on the OHP medical ID card.

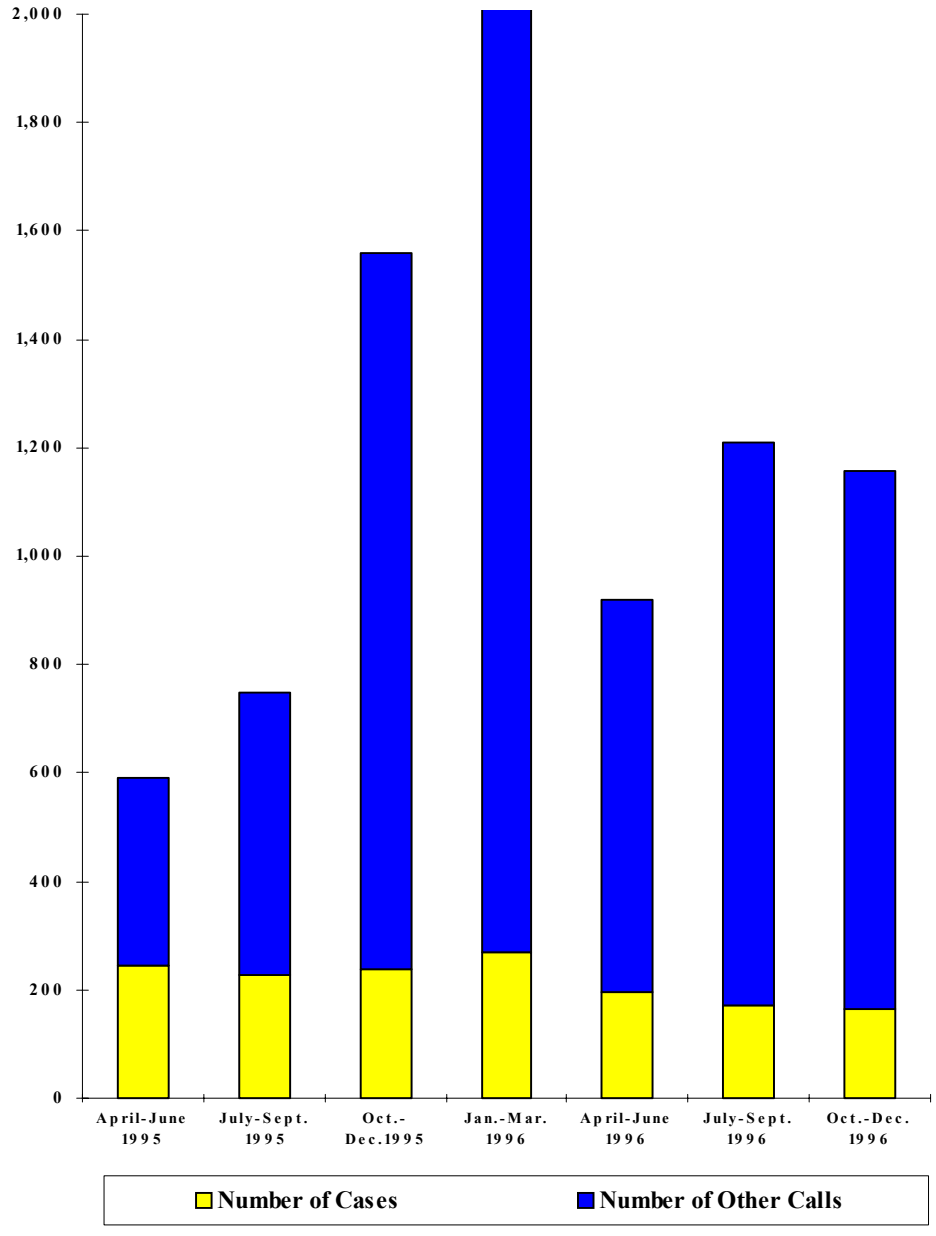
5.2.4 Exceptional Needs Care Coordination

Senate Bill 5530 also required managed care plans to establish a program known as Exceptional Needs Care Coordination (ENCC) which would provide both medical and social service case management for eligible persons age 65 or older or who have disabilities. Each managed care plan must designate at least one person to provide ENCC services. Typically, ENCCs have a nursing or social work background.

The ENCC is responsible for ensuring that the plan member has access to needed services. While this function is not targeted exclusively at coverage of services on the priority list, the ENCC can be instrumental in gaining coverage under a comorbidity criterion, can advocate on behalf of patients who are billed for services below the line

Figure 5-1

Number of Calls Taken and Cases Worked by the OHP Ombudsman



without first receiving the necessary notification, and can arrange for pro bono care if necessary.

In general, the ENCC is responsible for identifying individuals with complex, ongoing medical and social needs; ensuring their access to providers and services on a timely basis; working with medical providers to ensure that unique needs are met; assisting in discharge planning, and facilitating linkages to community support and social services; representing members' unique needs in the quality assurance and hearings/appeals processes[6]; identifying and eradicating barriers to care; documenting patient needs and care coordination efforts; and collaborating with the ombudsman to resolve member concerns.

ENCCs have recounted examples of how they were able to "be creative" in solving the special needs of their clients. One ENCC, for example, used health plan funds to purchase wood for heating a client's house in the winter. Another ENCC provided telephone service to an elderly client who was homebound. Other ENCCs have been able to purchase DME (e.g., electric wheelchairs, hospital beds) that would not be covered under traditional Medicaid, but which improves physical functioning and reduces the likelihood of hospitalization or institutionalization.

By all accounts, the ENCC program has been successful largely because the ENCCs are familiar with community resources, and as employees of the plan, they understand how

[6] The ENCC may advocate on behalf of the client to appeal denied services.

to leverage the health plan's resources. The role of the ENCCs in coordinating care for people with disabilities will be a central focus of the Phase II OHP evaluation.

5.3 Provider Responses to the Priority List

The priority list has provided the health plans with a document with which to identify services that are covered under the Oregon Health Plan. The plans can describe to providers the specific services for which they will be paid. In turn, the providers can use the list to provide an explanation to patients as to which services will and will not be covered by OHP. Most providers have an understanding of what falls below the cut-off line, but how this information is translated into practice differs from plan to plan and from provider to provider. Some providers have decided to continue to practice medicine as they always have in the past, not distinguishing an OHP patient from a patient with private insurance. If care is provided for which no reimbursement is provided, then the provider simply is not paid for services rendered. However, in some circumstances, "usual" care is collectively decided to be in the patient's best interest, regardless of whether payment is received.

An example of this behavior involves the surgical management of adults with symptomatic hernias. Although not covered by the current priority list, young working men with symptomatic hernias cannot work when their job involves lifting. Some provider groups have decided to fix the hernia even though they won't be paid. In Roseburg, the hospitals have had a "hernia day" on a weekend, where the surgeons donated their time and the hospital donated the operating room.

Other approaches to providing care may involve a creative use of the priority list. For example, tonsillectomy and adenoidectomy fall below the cut-off line on the priority list. However, there is a guideline specifying that tonsillectomy and adenoidectomy will be approved when the enlarged tissue is associated with obstructive sleep apnea related to upper airway obstruction. The frequency of obstructive sleep apnea among children and adolescents is believed to be increasing as a result of this coding phenomenon. One respondent suggested that more money is being spent performing sleep studies than the cost of the surgery itself. Thus, more money might be spent documenting the need for a procedure than the cost of practice as usual prior to the priority list.

Chapter 7 provides additional anecdotal evidence on the impact of the priority list on providers, based on provider interviews in three communities. Ultimately, however, the impact of the priority list on provider practice patterns is an empirical question. Our provider surveys will assess the impact of the priority list on provider practice patterns. In addition, we hope to undertake claims/encounter data analysis to assess patterns of care before and after OHP implementation.

5.4 The Priority List and the Phase II Population

5.4.1 Pre-Implementation Planning

Prior to the implementation of OHP, the HSC established two subcommittees to examine the applicability of the priority list to the Aged and Disabled populations. The subcommittees critiqued the existing priority list and provided additional ways of looking

at existing lines. In particular, there was concern about ensuring coverage of ancillary services. The subcommittees devised five dysfunction lines that could be used in situations where there is no treatment to improve health status, but rather a need for ancillary services to maintain health status. The five areas of dysfunction are: respiration, eating and elimination; posture and movement; short term rehabilitation services; communication; and reasoning and judgment. An example of service in a dysfunction line is the provision of physical therapy to maintain range of motion rather than to improve function. The dysfunction lines were developed to clarify coverage and quell fears among opponents of the priority list. However, the HSC justifies the lines because they eliminate an inconsistency within traditional commercial benefit packages, in which congenital conditions are not covered while conditions resulting from trauma are. The dysfunction lines eliminate this "bias." To date, the HSC has not heard complaints from health plans concerning these dysfunction lines.

In addition, five new lines were added for conditions that disproportionately affected the Aged and Disabled populations. The five lines covered medical treatment of fecal impaction, surgical treatment for spastic diplegia, treatment of non-neonatal achalasia, bone marrow transplant for hereditary immune diseases, and transplants for respiratory failure.

5.4.2 Reactions to the Priority List for People with Disabilities

Originally, advocates opposed inclusion of people with disabilities in the OHP demonstration, because they felt going to the prioritized list would take hard-fought benefits

away. However, the OHP benefit package B based on the Integrated List of Services B is richer than the traditional Medicaid fee-for-service benefit package. It covers such additional services as dental care for adults, preventive care for adults, hospice care, transplants for adults, and expanded mental health/substance abuse services for adults. OMAP administrators perceive that the advocates for people with disabilities who originally opposed OHP (especially the priority list) ultimately became advocates for inclusion of the Phase II population because of their access to more generous benefits.

In general, the priority list is well accepted among providers, advocates, and plans and is not believed to be to adversely affecting people with disabilities. Plans seem to have considerable latitude about what they pay for below the line; however, concern was expressed about the ethical implications of varying benefits and interpretations between plans. One plan estimated they cover 80 percent of the inpatient care that falls below the line, but only 20 percent of outpatient care below the line. Physicians are raised in a culture to provide (rather than deny) services, so much of what is below the line is hard to refuse.

When the line was raised in January 1996, repair of club foot (line 591) was no longer a covered service. Most cases are now referred to Shriners Hospital (Portland) and performed free of charge. If that is not convenient (for example, for children in Eastern Oregon) there is a feeling that plans pay for the treatment anyway upon approval by the plan's medical director.

Some plans have identified alternative resources for paying for below-the-line care. The ENCC at one plan noted they have used general SDSD funds to purchase non-orthopedic prescribed shoes for diabetics.

5.4.3 Implementation Issues

This section identifies four issues related to the priority list which may disproportionately affect the Phase II population. These issues include: the implementation of the comorbidity provision by managed care plans; how managed care plans differentiate between diagnostic services (which are covered) and treatment services (which are not covered) for below the line C-T pairs; issues surrounding the definition of medical necessity; and financial liability of below the line services.

The Comorbidity Provision. One intricacy in the implementation of the priority list, particularly as it affects people with disabilities, is the use of the comorbidity provision. Specifically, the State and managed care plans are required to cover treatments if there is a comorbidity that falls above the line. For example, surgical excision of an enlarged tongue (line 672) can be coded under airway obstruction and therefore qualify for coverage. As another example, the plan does not cover medical therapy (antihistamines) for the treatment of allergic rhinitis (line 639), but based on concerns raised by group homes, they will now cover the prescription for people with autism because of the impact of uncontrolled allergies on their behavior.

The comorbidity provision is not applied in a standardized way across plans. Some plans will contact a physician's office to see if there is a comorbidity before denying a service below the line. Overall, however, it is believed that the comorbidity provision is not well understood among OHP eligibles, plans, and providers. When advocates or providers have looked for and identified comorbidities, they usually have been able to obtain coverage for needed care. Better dissemination of information about this provision may contribute to a more uniform application of the provision across plans. One suggestion is to include information on the comorbidity provision with the denial notice, which not all plans seem to be doing.

Differentiating Diagnostic versus Treatment Services. Another issue identified by health plans has to do with the gray area of defining where "diagnosis" ends and "treatment" begins. Diagnosis of a below the line C-T pair is covered, while treatment *per se* is not. One plan has adopted a liberal policy, saying that services provided within a 30-day window for the same diagnosis constitutes treatment. After the 30-day window elapses, it constitutes a new diagnostic episode. This policy may allow treatment for an episodic condition like low back pain, for example. Again, this is an area where plan policies vary widely.

Defining Medical Necessity. A third intricacy surrounds the issue of medical necessity. Clients, plans, and providers may differ in what they consider medically necessary, especially in the areas of DME and ancillary services. For example, a client wanted a new lighter wheelchair so that it would be easier for a companion to maneuver and

facilitate transfers in and out of a car. The plan felt the older, heavier chair was adequate and a new chair was not a medical necessity (but rather for the convenience of the client). In another example, a plan limited the number of physical therapy sessions received by a client after deeming the previous amount of service was excessive. The State has intervened to replace the term "medically necessary" with "medically appropriate," which includes services, equipment, and supplies that are required for prevention, diagnosis, or treatment of a health condition or injury and which are:

- Consistent with the symptoms of a medical condition or treatment of a medical condition;
- Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
- Not solely for the convenience of an OMAP member or a provider of the services or medical supplies; and
- The most effective of the alternative levels of services or medical supplies which can safely be provided.

Despite the guidance concerning what constitutes medically appropriate care, managed care plans and clients continue to make different assessments of what services should be provided and what can be foregone. The ENCCs and OMAP ombudsman play a pivotal role in advocating for services which are medically appropriate. The State also has established an Ancillary Services Workgroup comprised of interagency representatives, advocates, and plans to focus on bridging the gaps between defining services that are medically appropriate and enhancing a client's functional status.

The Workgroup also is considering the complexity of coordinating acute care services (which are included in the capitation rate) and long-term care services (which are still paid on a fee-for-service basis). In particular, it has not been clear what services the health plans are responsible for covering (e.g., home health care, rehabilitation) and what OMAP will pay for.

Financial Liability of Below the Line Services. Another concern about the priority list is the potential financial liability incurred by OHP eligibles for below-the-line treatment. Some providers have billed patients for below-the-line care that is not paid by managed care plans. OMAP rules require providers to notify patients in advance that the treatment may not be covered and to have patients sign a statement of liability for uncovered services. One example was a Phase II patient with Crohn's disease who incurred $1,000 in physical therapy bills. The hospital billed the patient for the care because it was denied by the plan, but did not provide advance notification or have her sign a consent form. The ENCC intervened on behalf of the patient to inform the provider of the obligation to notify patients in advance, thereby eliminating the patient's financial obligation.

5.4.4 Integration of Mental Health Services

Beginning January 1995, the Integrated List of Benefits incorporated mental health and substance abuse treatment services. Mental health providers and advocates feel that the priority list is useful because it explicitly ranks mental health services relative to physical health services. Moreover, it enables people with nonpsychotic disorders to obtain care. In

particular, the Priority List covers somatic mental health conditions which had not been covered previously under Medicaid. Such conditions can be treated by primary care providers or specialty mental health providers.

When the line was raised in January 1996, four mental health services became unfunded (impulse disorder, conduct disorder, sexual dysfunction, somatoform disorder). However, it is strongly believed that almost all patients will have comorbid psychiatric disorders above the line, in effect rendering them covered services.

5.5 The Role and Future of the Priority List in the OHP Demonstration

The priority list is central to the OHP demonstration because it is intended to provide a mechanism for the State to allocate resources within a given budget constraint. As mentioned earlier, the State explicitly wanted to move away from more traditional means of controlling costs, such as limiting categorical eligibility criteria or reducing payments to providers. Instead, policy makers envisioned the priority list as a tool for managing costs by limiting the range of services provided.

The State has found that the priority list is a difficult way to manage a fiscal crisis. HCFA must approve all line changes before they can be implemented by the State. While awaiting HCFA approval of line changes, the State has had to look for other means of controlling costs. The State feels that this runs counter to the original intent of the demonstration.

When it has been necessary to raise the line, members of the HSC have struggled with the best approach to reviewing changes. For example, the Commission discussed the implications of moving from line 606 to line 581 (which was implemented in January 1996). Should some items remain covered even though the line was being raised? One position was that the lines were ordered systematically, and it would be inappropriate to change the position of any line without new data that might influence its location. Of concern is whether the repositioning fairly examines all lines, or if the "selected" lines were selected because of political or special interest pressure. Another position was that if a subset of lines was to be examined then perhaps the entire list should be examined because the movement of any line affects some other line that will become unfunded, and the lowest one left may no longer be the most appropriate. However, this proposal was met with grave practical concern that the Commission would not have the time and energy to reevaluate the entire list.

HSC maintains that one of the problems of the priority list is the Commission's inability to consider issues related to quality of life when ordering the lines. The initial placement of symptomatic adult hernia and club foot reflects these constraints. Providers do consider quality of life in discussing treatment strategies for patients. In the case of adults who could not work because of their symptomatic inguinal hernia, some physicians simply provided the surgery without charging the patient because not to do so would be reducing the patient's quality of life when a simple procedure could improve it dramatically. Such a decision may also be fiscally sound, since the patient could be removed from welfare

benefits and returned to the work force. Because the practice of medicine is more than maximizing the life span, issues related to quality of life will continue to undergo debate.

A salient question is: How much higher the line can be raised and still be considered a "basic benefit package"? OMAP administrators have felt the State legislature has not yet had to wrestle with whether there are limits to how high the line can be raised. This view was shared by some providers who viewed the priority list simply as a fiscal tool for resource allocation. Other providers expressed the view that the next movement of 20 or so lines could be problematic. In fact, HCFA denied the State's request to raise the line to line 573, approving a movement only to line 578. Whether this limits all future line movements remains to be seen.

In the meantime, some stakeholders would prefer that the State allow health plans to impose limits on the number, frequency, or annual costs of diagnostic services, physical therapy encounters, and/or mental health services, similar to those in commercial benefit packages. Advocates of service limits argue that providers and members might work harder to achieve a goal if it were clear that charges would not be reimbursed beyond a certain limit. The problem with this approach is that if the OHP benefit limits begin to resemble commercial benefit packages, there is no longer a safety net for those with more intense and complex medical needs.

To date, the priority list has not yet really tested the public's and providers' willingness to accept "tough choices" between coverage of more people/fewer services versus more services/fewer people. Few needed services currently fall below the line. Thus,

providers are basically able to provide all of the usual and customary care and be reimbursed for their services. In special situations, such as adults with symptomatic hernias or patients with warts, some physicians provide services without additional charge.

The Oregon Health Plan has faced budget shortfalls virtually every year, requiring interim requests for changes in the cut-off line, changes in the eligibility criteria, reductions of health plan and FFS payment rates, and other policies and procedures designed to reduce OMAP spending. To date, the demonstration has shown that the priority list alone is not enough to manage budget shortfalls. Moreover, it remains to be seen whether further line movements will be possible while still preserving a basic benefit package.

6 Employer and Private Health Insurance Issues

The Medicaid demonstration was implemented in the context of a broad statewide health insurance reform effort in Oregon. The Medicaid demonstration constitutes the Federally-funded part of this broader effort. This chapter describes: (1) the private sector components of the Oregon Health Plan (OHP) and the way in which the Medicaid demonstration interacts with them, (2) the history of political support for OHP in the private sector, (3) the role of the Office for OHP Policy and Research, and (4) the interaction of the Medicaid demonstration with the private insurance regulatory structure.

6.1 Private Insurance Reform in the Oregon Health Plan

In addition to the Medicaid demonstration, OHP includes several State-initiated programs to make private insurance more readily available and affordable to Oregonians. None of these initiatives receive Federal funding. The five major components of OHP in addition to the Medicaid demonstration are:

1. The ***Oregon Medical Insurance Pool***, a high-risk insurance pool for individuals who have been denied health insurance for medical reasons, but who can afford to pay for it from their own resources.

2. The ***Insurance Pool Governing Board***, an independent agency reporting to the Governor, that developed a low-cost plan for small employers.

3. The ***Small Employer Health Insurance Reform Program***, which requires all insurers participating in the small group market to meet certain standards for product design and practices.

4. The ***Employer Mandate***, which required all employers in Oregon to offer health insurance by January 2, 1998. However, the mandate automatically became void on January 2, 1996 in the absence of an ERISA exemption.

5. Creation of the ***Office of the Oregon Health Plan Administrator*** to coordinate the Medicaid and private insurance initiatives with other State agencies, the Oregon Legislature, and private groups. This office is now known as the Office for OHP Policy and Research.[1]

Although the employer mandate and the small business insurance programs are separate from the Medicaid demonstration, they are important to its success. The waiver cost estimate for the Medicaid program assumed that Medicaid beneficiaries who are employed would shift to employer coverage by February 1997. Under the assumption of Federal budget neutrality, the program may not be able to meet projected expenses with the demise of the employer mandate unless the State contributes additional State revenues or reduces program costs.

6.1.1 Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (OMIP) is a typical high-risk pool for persons who have been denied coverage or been quoted excessive premiums for individual coverage for medical reasons. It was created by Senate Bill 534 in 1987. The pool provides individual coverage for a premium equal to 150 percent of the average non-group premium charged by the five largest carriers of non-group health insurance in Oregon. Eligibility is limited to persons living in Oregon for at least six consecutive months or who are

[1] Refer to Chapter 2 for additional background on the Office of the OHP Administrator.

transferring from another state's risk pool within 31 days of losing coverage in the other State. In June 1997, 4,387 policies were in force, covering 5,144 persons. Annual loss ratios since 1991 have ranged from 125 to 182 percent. Health insurers and reinsurers are assessed to cover the losses. OMIP offers a choice of a traditional indemnity plan, a PPO, and, in 32 counties, a managed care plan. There is also a low-cost "portability" indemnity plan designed for persons who lose coverage. BCBS of Oregon serves as the third party administrator for OMIP, with administrative costs running at 6 percent.[2]

6.1.2 Insurance Pool Governing Board

The Insurance Pool Governing Board (IPGB), also created in 1987, is a voluntary program for employers of 1-25 persons who have not offered health benefits within two years. It tries to make coverage more attractive to small businesses by sponsoring the development of low-cost basic plans and providing tax credits for employers who participate. Insurers are permitted to underwrite. The original premium for the basic package was $53.33 per employee per month ($40 for the employer and the lesser of 25 percent or $15 for the employee), but participating insurers are permitted to offer richer plans as well (up to $174.15 in 1994). The plans achieve their low cost by using a sliding deductible based on medical underwriting. With inflation, benefits were decreased to maintain the set premium rate, but in 1993 the Legislature increased the set rate to $56 to

[2] The sources for these descriptions of OMIP and the other OHP components are the *Oregon Health Plan Status Report* (February 2, 1994), the *Employer Based Insurance and the Employer Mandate* (January 1, 1995), both prepared by the Oregon Health Plan Administrator, and discussions with the staff of the Insurance Pool Governing Board and the OHP Policy and Research Office.

offset some of this erosion. Three insurance carriers (BCBS of Oregon, Physician Association of Clackamas County, and PacifiCare) and three HMOs (Regence HMO Oregon, Kaiser, and Sisters of Providence) participate. The legislation provided tax credits for a five-year period starting at $25 per member per month and declining according to a specified schedule to $6.25 in the last 18 months. Although the initial tax credit was very generous, employers were unable to take advantage of it because the schedule for its reduction was fixed in law and delays in starting the program meant that they had already decreased by the time the program became operational. In June 1997, the program covered 31,806 persons and over its life had enrolled a total of 57,331 up from 27,000 in January 1994. About 11,000 businesses participated in the IPGB program in June 1997.

6.1.3 Small Employer Health Insurance Reform Program

The Small Employer Health Insurance (SEHI) Reform Program, enacted in 1991, called for the development of a guaranteed issue policy with benefits substantially similar to Medicaid benefits for firms with 3-25 workers. All insurers offering small group products (about 35) are required to offer it, but they may offer other underwritten plans as well if they meet standards established by the Act for premiums and pre-existing conditions. The guaranteed issue plan, called the Basic Health Plan, uses rate bands and varying coinsurance rates. Nevertheless, it is expensive because the benefits are relatively rich and it experiences adverse selection. Only groups that cannot qualify for the less expensive underwritten plans are likely to buy it. Therefore, only about 460 groups were enrolled in June 1994. The OHP

administrator believes that insurers are more willing to sell other, more flexible plans to small groups as a result of this guaranteed issue product because they know they have to provide a quote on this plan.

In addition to creating the guaranteed issue product, this legislation established standards that all small business products must meet. These requirements include limits on variation among rate bands, geographically averaged rates, caps on the size and frequency of rate adjustments, prohibition of exclusions of individuals within a group, guaranteed renewal (with some exceptions), limitation of pre-existing condition exclusions to six months with credit for prior coverage, prohibition on classifying pregnancy as a pre-existing condition, and disclosure of rate structures and limitations.

6.1.4 Employer Mandate

Oregon's employer mandate required employers to cover all permanent employees or be taxed by a fund which would provide coverage. The tax would be roughly equal to the cost of providing coverage. The mandate required firms with 26 or more workers to offer insurance by March 31, 1997 and firms with fewer than 26 workers to offer insurance by January 1, 1998.

Successful efforts to pass an employer health insurance mandate are very unusual because groups representing employers generally lobby against them. Oregon was able to pass the mandate because the effort occurred in the context of the broader statewide health insurance reform initiative that included existing private health insurance plans and the

Medicaid program. Legislative proponents created a cooperative atmosphere with a broad-based discussion of how Oregon should use all of its health care resources. This approach focused on improving the cost-effectiveness and efficiency with which health care resources are used and emphasized the interdependence of private and public insurance plans, particularly with respect to cost-shifting. It also coincided with the public debate surrounding the creation of the priority list. The appeal to efficient use of resources through universal coverage and the use of a priority list attracted employers who already offered health insurance and were, therefore, subject to cost-shifting from the uninsured population. Associated Oregon Industries, an industry association representing firms of all sizes, supported the measure, while the National Federation of Independent Businesses, which mainly represents very small employers, opposed it.

Although the mandate legislation was enacted, opponents were able to specify two conditions that would result in its cancellation prior to implementation. The original legislation contained language that would void implementation if 150,000 additional persons were covered by voluntary private insurance before the implementation date. The IPGB was required to make this determination before the mandate could be implemented. In 1993, the State legislature imposed the additional requirement that an ERISA exemption had to be obtained by January 2, 1996 or the mandate would be voided. This requirement stemmed from concern over the amount of time it would take to implement the mandate following receipt of an exemption, but it was also viewed by the mandate's opponents as a way to

impede it, given that ERISA exemptions have never been granted. Indeed, this is the condition that ultimately led to the demise of the employer mandate.

Moreover, the political consensus needed to implement the employer mandate has evaporated within the State. Following the shift in both houses of the Legislature to Republican control in the November 1994 elections, the Legislature passed a bill repealing the employer mandate. Governor Kitzhaber, the new Democratic Governor elected in November 1994, was the originator of the mandate and he vetoed the repeal act. Nevertheless, there has been no action at the Federal level to create an ERISA exemption for the Oregon Health Plan and, thus, the mandate was void on January 2, 1996.

The projected shift of employed OHP beneficiaries from Medicaid to employer-sponsored health plans in 1998 was an important element of the original budget assumptions for OHP. Without the employer mandate, it is unlikely that the shift would have occurred and the State would have been forced to find additional funds for OHP or reduce costs under the assumption of Federal budget neutrality. Options included:

- Imposing additional taxes,
- Shifting existing State revenue from other uses,
- Lowering capitation rates from reasonable cost to some lower proportion of cost,
- Introducing copayments and/or deductibles,
- Introducing premiums,
- Raising the line on the priority list,
- Excluding selected groups of persons from coverage.

The last three options on the list were implemented in FY 1996. In November 1996, approval of Ballot Measure 44 authorized a tax on tobacco products to support expansions

of the Oregon Health Plan. Three expansions are planned for 1998 using these funds. The first two expand Medicaid eligibility to: (1) reinstate approximately 1,700 full-time college students who are eligible for Pell grants (college students were made ineligible in FY 1996 because of budget limitations), and (2) cover 1,800 additional pregnant women and 25,000 children through age 11 under the Poverty Level Medical (PLM) program. The third expansion involves the private insurance market. The Family Health Insurance Assistance Program (FHIAP) will subsidize private insurance premiums for group or individual coverage for approximately 20,000 adults and children, easing the potential budget problem caused by the loss of the employer mandate.

6.2 Private Sector Support for OHP

The Medicaid demonstration in Oregon resulted from a political consensus built around statewide health insurance reform. Governor Kitzhaber led this effort as a state legislator prior to being elected Governor. However, the participation and support of private sector employers and the insurance industry was key to achieving the consensus, particularly with respect to the priority list and the employer mandate.

Two advisory groups were established to assist in the design and implementation of OHP. The Oregon Health Council (OHC), which advised the Legislature and the state Office of Health Policy on the design of OHP, was composed of representatives from government, the academic and medical communities, the insurance industry, and large

employers. More recently, the OHC has been involved in the design of the Family Health Insurance Assistance Program.

The Oregon Health Reform Implementation Group (OHRIG), which advises the OHP Administrator, is composed of many of the same individuals and organizations, but it has a larger and more diverse representation from the insurance industry and small employers. The members of these two groups were closely involved in the development of OHP and the reasoning in support of it. We interviewed several members of both groups to understand the rationale of the insurance industry, large employers, and small employers in supporting or opposing various aspects of the OHP.

Perspectives of Large Employers. Large employers almost always provide health benefits. Therefore, we would expect them always to support mandated health benefits because it minimizes the subsidy conveyed to employers who do not provide health benefits. Nevertheless, most employers who offer health benefits oppose mandated health benefits because they are philosophically opposed to regulation, believe that it may have a negative effect on the economy as a whole, and perceive that mandates will extend to the structure of their own plans in addition to simply requiring all employers to provide health benefits. Large employers were particularly concerned that the mandate would establish a standard benefits plan that would prevent them from customizing their own plans.

Despite these concerns, large employers were attracted by the idea of a cooperative effort of government, large employers, and small employers to devise a comprehensive system that would be based on a rational allocation of resources. The priority list was

perhaps the most important factor in attracting employers because they saw it as the element of OHP that most strongly embodies the concept of rational resource allocation and living within one's means. Business executives often complain (whether justified or not) that the chief failing of government is the absence of concern for rational allocation and budgetary responsibility. They saw the priority list as an opportunity to introduce these values into the Medicaid program. Business executives also were committed to the development of managed care and saw OHP as a way to replace piecemeal insurance regulation that hindered the expansion of managed care with a simpler structure that would encourage it. Thus, they were willing to accept the employer mandate as one part of the entire OHP package that contained several other highly-appealing elements.

The Medicaid reforms were the least controversial elements of OHP for the large employers. They tend to be much more concerned with the cost shift from Medicare and Medicaid to private health plans through low reimbursement rates than with the inter-employer cost shift from free riders. Thus, they found the increased Medicaid reimbursement rates particularly attractive.

Perspectives of Associated Oregon Industries. The support of Associated Oregon Industries (AOI), the chief business association in Oregon representing about 2,000 companies of all sizes, was a key to the success of OHP legislation. AOI supported both the Medicaid demonstration and the employer mandate because it embodied several key principles for AOI, including: rational resource allocation through the priority list, the use of general revenue to finance the state contribution, and shared responsibility between the

public and private sectors. But AOI expressed concern that these principles had been violated in the following ways:

1. The priority list was designed to cope with difficult decisions about resource allocation. But the initial benefit package excluded almost nothing. The rationale for ranking services was that the placement of the line would reflect the Oregon economy and resources available. Ballot measure 5 in 1991 significantly reduced state revenue and the line should have shifted to reflect it, but it was not moved. In AOI's view, ethical problems created by raising the cut-off line must be balanced against the ethics of denying care to persons who might lose coverage entirely if the line did not move to reflect available resources.

2. The original concept called for the use of general revenue to finance OHP because OHP is viewed as a social program. However, rather than move the line in response to a decline in general revenue, the state imposed a cigarette tax. The use of general revenues tends to make the social and political choices between increasing revenue and decreasing coverage more explicit. Special taxes that apply to only a segment of the public tend to mask these choices.

3. The OHP concept initially called for the State to be responsible for persons earning 100 percent FPL or less and private employers to be responsible for persons earning more than 100 percent FPL. However, AOI believes that this principle was violated when the State assigned responsibility for employed persons earning 100 percent FPL or less to their employers to achieve Federal budget neutrality. Furthermore, the mandate required the employer to cover 75 percent of the employee premium but it does not makes sense to require low-income employees to pick up the balance.

State Medicaid staff believe there was a misunderstanding about employers' responsibility for insuring workers under the poverty level. It was the State's understanding that, under the employer mandate, workers under 100 percent FPL would have primary coverage through their employers and secondary coverage through Medicaid. Employees with incomes below poverty could apply for OHP, and if eligible, the State would pay the

employee's share of the premium if cost-effective to do so. Otherwise, if it was not cost-effective, the employee would receive health insurance through OHP. OMAP felt that it would not be workable to distribute the population completely on the basis of income because: (1) employers do not know the family income of their workers, only the salary they pay the employee, and (2) it would provide a perverse incentive to offer insurance only to workers over the poverty level and to then keep salaries below the poverty level to avoid paying for health insurance.

Perspectives of Small Employers. Small employers would have been affected most directly by the employer mandate because they are least likely to offer health benefits.[3] Site visit interviews with representatives of the Oregon affiliate of the National Federation of Independent Business (NFIB), small business owners, and insurance brokers who sell small group insurance policies provided information about how the employer mandate was viewed by small businesses in Oregon. NFIB was neutral toward the Medicaid demonstration, hoping it would encourage welfare recipients to find work by allowing them to keep their medical benefits, but vociferously opposed the employer mandate. Members who did not offer insurance did not want to be required to do so. Members who offered insurance also opposed the mandate because they opposed government regulation and were concerned that they would be forced to contribute toward the premiums for dependents. Many small firms that offer insurance now require the employee to pay 100 percent of the premium for dependents. Furthermore, offering health benefits gives small employers a competitive

[3] Nationally, more than half the firms employing 5-9 workers offered health benefits in 1989, but only 14 percent of firms employing 1-4 workers offered them.

advantage in the labor market; for example, by making it easier to fill vacancies. They do not want to see this advantage eliminated by the mandate, even if it would reduce their own insurance costs by eliminating the pricing advantage enjoyed by competitors who do not incur the expense of health benefits.

In contrast to these reports about the attitudes of most small businesses owners, the owner of a 6-employee firm who offered health benefits believed that it was important to provide access to quality care for everyone. He is particularly concerned about small firms that provide insurance to management but not workers. Thus, he strongly supported the employer mandate but felt that unless employees are also required to take the insurance (i.e., a parallel employee mandate), firms would begin to use health status as a screen for employment. He also felt that NFIB does not accurately represent small employers in Oregon because its membership recruiting practices result in a bias towards firms that are the most penurious.

Summary. The attitude of the business community toward OHP was clearly split. OHP, in general, and the employer mandate specifically, succeeded in the Legislature largely because of support from the larger employers and AOI who perceived it as a way to impose order on a chaotic system. Support for the mandate eroded because, during the years since its enactment, employers who were initially reticent about the mandate had the chance to see it as an individual program rather than as part of the larger OHP package. Thus, objections became more focused. Furthermore, the details of how it would be implemented were never

worked out. Employers who accepted it as a vague element of the larger package became increasingly uncertain of how it would affect them.

In short, the employer mandate was always the most controversial and least supported element of OHP. It took a concerted effort to create the coalition needed to include it in OHP; but with time, the energy needed to hold that support abated, and the mandate, as the least popular element, was the first to disappear.

6.3 The Office for Oregon Health Plan Policy and Research

The Office for Oregon Health Plan Policy and Research (formerly known as the Oregon Health Plan Administrator) is responsible for coordinating the private and public sector elements of OHP and for future private sector initiatives. Following eligibility limitations and cost sharing provisions implemented in FY 1996, the OHP Policy and Research office focused on expanded coverage alternatives for special populations, such as children and the near poor up to 150 percent FPL, rather than broad-based expansions such as the rejected employer mandate. Concepts under consideration included:

- Developing a "children only" benefit package for private insurance plans so that employees who decline coverage for themselves can take it for their children.
- Providing tax credits for employers and employees to subsidize and encourage coverage.
- Working with Associated Oregon Industries to educate employers about issues such as the cost-shift from employers who do not provide health benefits to those that do and to develop a privately-sponsored small business purchasing cooperative.

- Developing the Oregon Scorecard to rate managed care plans.

- Exploring the use of the public employees health benefits plan as a mechanism for covering individuals in the private sector. (Opening up the state employees plan to other citizens is a health system reform mechanism under consideration in other states as well.)

- Conducting research on the implications of OHP on the Oregon economy, including the private sector initiatives, the Medicaid demonstration, and the loss of the employer mandate. Outcomes of interest include labor force participation, uncompensated care, and whether OHP has spread private-sector managed care to parts of Oregon that never had it.

Some of these initiatives, such as the AOI purchasing cooperative and the Scorecard project, are currently underway and, as discussed above, the three expansions funded by the tobacco tax are scheduled to take effect in 1998.

6.4 Insurance Regulation

An important characteristic of OHP and its widespread use of managed care is that it shifts responsibility for much of the day-to-day financial and clinical operation of the Medicaid program to the private sector. The Insurance Division, located within the Oregon Department of Consumer and Business Services, licenses health insurers and HMOs and monitors solvency and market conduct (e.g., grievances). It also reviews and approves premium rates for individual products, but not for group products. Oregon recognizes two types of health insurers: (1) traditional insurance companies, which are usually health and life companies but also may be property and casualty companies, and (2) health care service contractors (HCSCs), which include BCBS and HMOs. HCSCs are provider-based or are

intimately connected with providers. They have slightly lower surplus and reserve requirements and do not participate (as contributor or recipient) in the solvency guarantee funds that traditional insurers are required to participate in. Instead, they must include in their provider contracts a "hold harmless" clause by which providers promise not to seek to recover fees from patients if the insurance plan fails.

The Insurance Division licenses OHP health plans that have contracts with private sector groups as well as OMAP, but it does not license the Medicaid-only plans that have developed for the Medicaid component of OHP. All but one of the OHP health plans regulated by the Insurance Division are licensed as HCSCs. ODS Health Plan is a property and casualty company, but ODS Dental is an HCSC.

Although OMAP has developed its own financial monitoring system for all OHP health plans, the plans that serve commercial groups as well as Medicaid are also monitored by the Insurance Division. The plans report on their financial status annually and receive a detailed audit every three years. Reporting for the Insurance Division does not distinguish the health plan's performance by insured group. Thus, there is no specific focus on the impact of the Medicaid program on financial status. However, if a financial weakness is observed, it is investigated to determine the cause. To date, OHP has not been an issue in any review; however, under the three-year cycle, some participants have not undergone the detailed audit since OHP began.

The financial monitoring performed by OMAP and the Insurance Division are independent of each other. Presumably, the Insurance Division, OMAP, and other

significant member groups would work together to resolve serious problems in the event of financial distress within a health plan that serves commercial and Medicaid clients. However, a problem of this type has not yet occurred.

Dual oversight by OMAP and the Insurance Division serves the respective legislative mandates of both agencies. Health plans tend to view Medicaid (and Medicare) contracts as simply one of many group contracts, albeit one that carries greater oversight by virtue of its legislative mandates and public trust. When health plans decide to accept these contracts, they accept greater oversight than they usually receive from commercial clients, who tend to rely on regulatory oversight by the Insurance Division to protect their financial interests.

7 Impact of the Oregon Health Plan on Providers: A Tale of Three Communities

Providers were among the key supporters of the Oregon Health Plan (OHP) during its inception and development.[1] They favored the expansion of Medicaid eligibility to improve financial access among the uninsured (and reduce their level of uncompensated care). Moreover, with the increased fees to minimize cost-shifting, Medicaid reimbursement was being viewed more favorably within the private medical community.

Physician concerns centered on the accelerated growth and diffusion of managed care and the implementation of a prioritized list of benefits. Although managed care was prevalent in Oregon prior to OHP, it was concentrated in the Portland metropolitan area and a few other urban pockets. Under OHP, managed care was destined to spread virtually statewide. Moreover, implementation of the priority list was a complete "unknown." While in theory there was widespread support for the prioritization of benefits, physicians were not sure how it would affect their practices in reality.

At the outset, public and community-based providers were less certain about their role in OHP. Long the providers of last resort when private providers closed their doors to indigent patients, it was unclear how Federally-qualified health centers (FQHCs) would fare when they were no longer assured facility-specific, cost-based reimbursement, and when

[1] In fact, the program's architect (and now Governor), John Kitzhaber, is a physician.

they faced increased competition for patients. The role of public health departments was evolving as well.

As part of our evaluation, we sought to understand how private and public providers had been affected by the Oregon Health Plan, including the impacts of managed care, the introduction of the priority list, and the expansion of Medicaid eligibility. Our approach was to conduct intensive site visits in three communities in Western Oregon - Hood River, Roseburg, and Salem (see Figure 7-1).[2] We met with private practice physicians (primary care and specialists), physician office staff, public health department directors, hospital administrators and emergency room staff, and staff of Federally Qualified Health Centers (FQHCs) and other clinics. All visits took place during October 1995.

The three communities were chosen primarily because of the competitive environment in which OHP was implemented. Physicians in Roseburg, for example, chose to form their own Independent Practice Association (IPA) and contract directly with the State as a prepaid health plan under OHP. Their plan has become a model for other communities that are beginning to form regional IPAs to contract directly with OHP. Salem faced considerable provider shortages *before* OHP, distinguishing Salem as an important community within which to evaluate provider issues under OHP. Hood River was chosen because it is a relatively rural county, with a substantial seasonal and migrant population. An FQHC serves the migrant, largely Hispanic, population.

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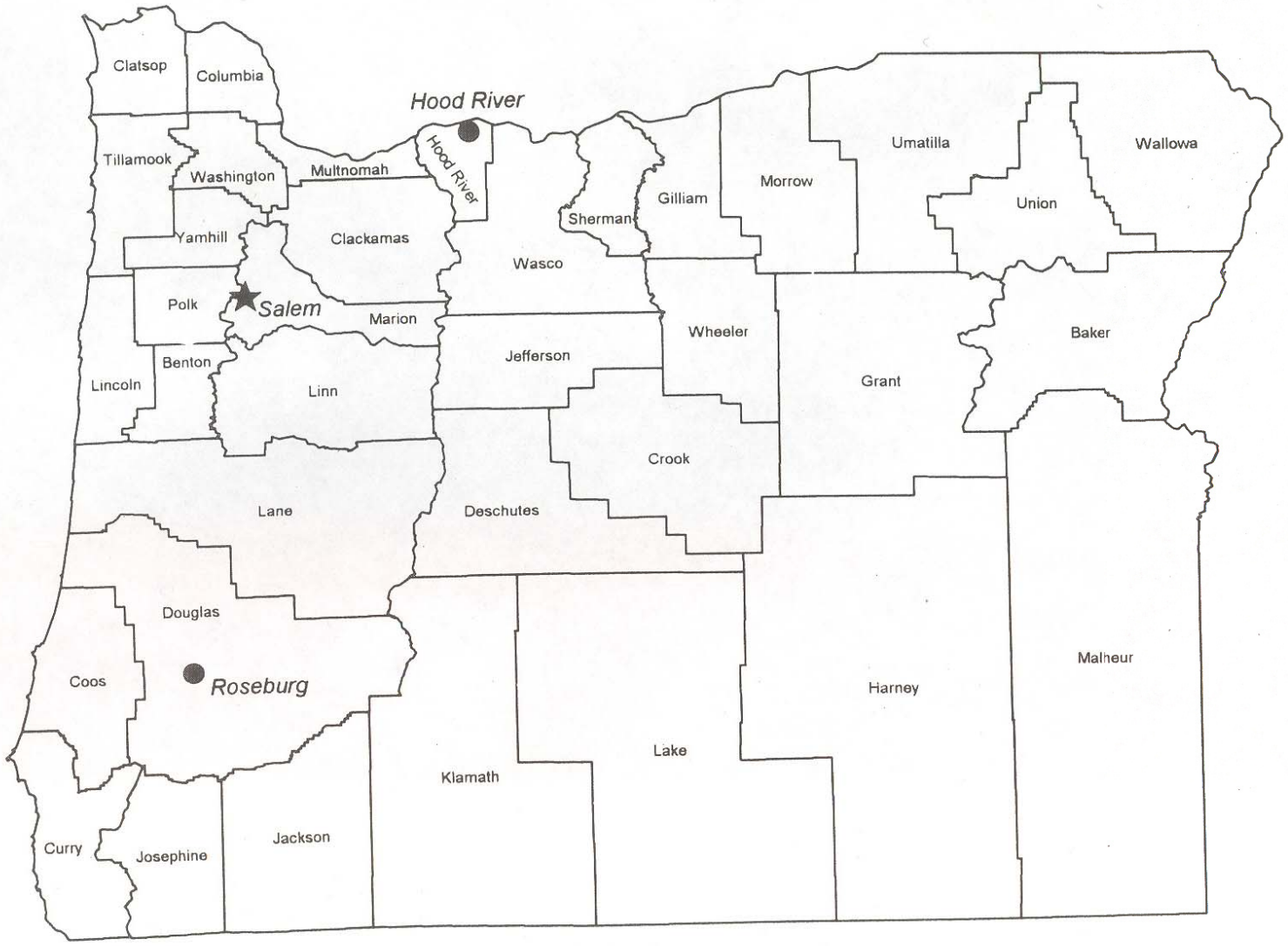
[2] We also plan to conduct a survey of approximately 1,000 physicians in Oregon to obtain empirical information on the impacts of OHP on their practice and their opinions about the program.

Figure 7-1
Provider Case Study Sites



This chapter describes how providers in the three communities have adapted to the Oregon Health Plan. Through these case studies, we learned how providers have responded to the expansion of managed care, how they feel about the priority list, how they think the program has affected access, and what types of administrative problems they have encountered. We begin with a profile of the three communities, including demographic characteristics and an overview of the health care environment. Next, we discuss the establishment and evolution of independent practice associations (IPAs) in the three communities, followed by a synthesis of OHP impacts on providers. We conclude with a summary of key themes.

7.1 Community Profiles

7.1.1 Overview

Table 7-1 provides a profile of demographic and health service characteristics in the three case study communities. The counties present a mix of urban and rural localities. Marion County, home of Salem and the State capital, is the third most densely populated county in the State (behind Multnomah and Washington counties), while Douglas County (home of Roseburg) and Hood River County (home of Hood River) are much more sparsely

Table 7-1

Profile of Three Communities

	Douglas County (Roseburg)	Hood River County (Hood River)	Marion County (Salem)	Oregon
Population				
Total Population (1992)	96,517	17,232	239,324	2,971,567
Population Per Square Mile	19	33	202	31
Income and Poverty				
Per Capita Income	$10,809	$11,421	$12,228	$13,418
Percent Below Poverty	14.9%	15.7%	13..2%	12.4%
Unemployment Rate	8.6	8.6	6.3	620.0%
Ethnicity				
Percent of Hispanic Origin	2.4	16.3	8.0	4.0
Percent Speaking Language at Home Other than English	3.4	15.8	10.7	7.3
OHP Enrollment				
OHP Eligibles	14,954	2,387	33,839	364,060
OHP Eligibles as a Percent of Total Population	15.5%	13.9%	14.1%	12.3%
OHP Managed Care Plans	2	2	6	20
A55% OHP Eligibles in Managed Care	89.9%	82.2%	8486.4%	8199.6%
Health Care Delivery System				
Number of Patient Care Physicians	128	29	408	6,354
Physicians Per 1,000 Population	1.33	1.68	1.70	2.14
Number of Hospitals (1)	3	1	3	63
Number of Beds	254	32	506	7,476
Number of Beds per 1,000 Population	2.63	1.86	2.11	2.52
Number of FQHCs	0	1	2	8

(1) Includes non-Federal short-term acute care hospitals.

SOURCES: U.S. Bureau of the Census. County and City Data Book: 1994. Washington, D.C.: U.S. Government Printing Office, 1994.
OHP Enrollment Report, December 1995.
American Medical Association. Physician Characteristics and Distribution in the US, 1995/96 Edition.
American Hospital Association. The AHA Guide to the Health Care Field, 1995/96 Edition.
American Hospital Association. Hospital Statistics, 1994/95 Edition.
Bureau of Primary Health Care. BPHC-Supported Primary Care Centers: Directory, April 1993.

populated. The two rural communities have among the highest rates of poverty and unemployment. In fact, the unemployment rate in Douglas and Hood River is more than two points above the statewide rate. Marion and Hood River counties have a significant Hispanic population, as well as a large share of the population whose first language is not English. These two counties are served by three FQHCs, including two in Marion County and one in Hood River.

The rate of physicians per capita in Oregon (2.14 per 1,000) is similar to the Nation as a whole (2.10 per 1,000). However, the three communities in our case study were below the statewide level (averaging 1.33 to 1.70 per 1,000). On the other hand, hospital bed supply in Oregon is below the national average (2.52 versus 3.61 per 1,000), with one of the three communities (Hood River) having less than two beds per 1,000 residents.

As might be expected from the income and poverty statistics, the three communities have a higher share of population enrolled in OHP than the statewide average. Managed care enrollment is highest in Douglas County, where physicians formed an IPA and developed a prepaid health plan in response to OHP. This may have served as a catalyst for the high managed care enrollment rate in the county.

7.1.2 The Health Care Community in Hood River

Hood River is a small community in the Columbia Gorge whose main industries are agriculture and tourism (windsurfing and skiing). The area is served by two hospitals, Hood River Memorial Hospital (a non-profit community hospital located in Hood River) and Mid-

Columbia Medical Center located in The Dalles of Wasco County. Competition stares the Hood River hospital in the face every day, as the Mid-Columbia Hospital has established an urgent care center directly across the street from the Hood River Memorial Hospital. Mid-Columbia Hospital primarily serves specialists, while Hood River relies largely on primary care providers.

There are 28 physicians in Hood River, of whom 13 are general/family practitioners. Hood River's primary care physicians serve a population of 18,000, giving the community one of the lowest number of patients per PCP in the State. In recent years there has been an influx of primary care providers, attracted primarily by the windsurfing, skiing and general quality of life within the county. The PCPs have an unusually wide scope of practice in this community as demonstrated by their ability to admit to the intensive care unit, provide obstetrical care (including Cesareans), and perform general surgery.

Specialty care is provided by visiting physicians from Portland. Dermatology, hematology, and cardiology specialists and an allergist are available one-to-two times per week at the Mid-Columbia Medical Center in The Dalles. Other specialists, such as ENT, urology, orthopedics and OB/GYN, are available from The Dalles at Care Corner, an urgent care center built by Mid-Columbia Medical Center but located in Hood River. High risk OB cases are referred to Oregon Health Sciences University (OHSU) in Portland.

La Clinica del Carino Family Health Center is an FQHC whose caseload is 60 percent Hispanic. All direct patient care staff are multilingual. Their service area captures 23 percent of the Native American population in Oregon. The clinic is staffed by five

physicians (all board certified in family medicine), two physician assistants, and 50 other FTEs. La Clinica physicians are affiliated with the IPA through individual contracts. There is a subassignment of fees to the clinic under a separate contract.

Because the county has an adequate supply of primary care providers (including the FQHC), the Hood River health department concentrates on core public health functions. They contract with the health plans for "carve-out" services such as communicable diseases, STD treatment, and immunizations, which are billed directly to OMAP. In addition, the health department bills OMAP for family planning services.

At the time of this case study, two managed care plans held the OHP contracts in Hood River: ODS Health Plan and HMO Oregon. The OHP was the impetus for the formation of an IPA, which contracted with the two plans. The IPA now contracts exclusively with a regional plan, Central Oregon Independent Health Services (COIHS).

7.1.3 The Health Care Community in Roseburg

About three hours south of Portland on the 1-5 corridor, Roseburg (population 18,600) is the county seat and principal market town for Douglas County (population 97,000). Until recently, Douglas County had been almost entirely timber dependent with a labor market characterized primarily by seasonal employment. At one point, the county's unemployment rate had risen as high as 17 percent. Now, however, the timber industry is 'fairly healthy' and the economy has diversified somewhat, with tourism becoming an important focus. In addition, a large Indian casino being developed south of town is

anticipated to become a major employer. The county encompasses a large geographic area, and many of its lower-income residents live in comparatively remote areas without transportation.

Roseburg Health Enterprises Inc. (RHEI) is the sole OHP health plan offered throughout most of Douglas County. RHEI is a subsidiary of the Douglas County Independent Practice Association, a 120-physician organization. Except for those physicians in the Reedsport area (near Coos Bay),[3] the IPA includes all but a few active physicians in the County. RHEI was established in response to the RFA issued for managed care contractors under OHP. RHEI is the sole OHP health plan offered throughout most of Douglas County, with 11,800 OHP members as of July 1997.[4]

Roseburg has two 100+ bed community hospitals, Douglas County Community Hospital and Mercy Medical Center.[5] Douglas County Community Hospital, a Columbia (i.e., proprietary) hospital has a comparatively old facility on a confined parcel of land. The non-profit Mercy Medical Center, on the other hand, has an attractive new facility surrounded by an expansive medical campus which includes a nursing home, assisted living housing, and medical office park. The two hospitals -- Douglas County Community Hospital and Mercy Medical Center -- compete fiercely for Roseburg's shrinking inpatient population. With each hospital operating at 50 percent occupancy, it is generally agreed that

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[3] The Reedsport physicians chose to contract with HMO Oregon.

[4] HMO Oregon had an additional 884 members (6.4 percent).

[5] Roseburg also has a large, very old Veteran's Administration hospital that apparently provides little or no service to community residents.

Roseburg requires only one hospital. Recent merger negotiations between the hospitals failed, and the two continue to compete directly for patients. Although 95 percent or more of community physicians have admitting privileges at both hospitals, the doctors tend to have strong attachments to either one hospital or the other. Tertiary care referrals typically go to Eugene, a metropolitan area located roughly 60 miles north of Roseburg.

Prior to OHP, Medicaid-eligible and other lower-income residents received most of their care either from the Douglas County Health Department or the emergency rooms at the two hospitals. The health department provided communicable disease treatment, a child health clinic, in-home services for children, a teen health center, a prenatal clinic, home health care, and family planning. With the implementation of OHP and the expansion of private physician participation in Medicaid, the health department has discontinued its child health clinic and has reduced its prenatal care capacity.

7.1.4 The Health Care Community in Salem

Salem is the State capital and the seat of Marion County. It is the population center of the two-county medical service area comprised of Marion and Polk Counties. At the time of our visit, CareOregon, HMO Oregon, ODS Health Plan, Kaiser, QualMed, and PacifiCare were the six fully capitated OHP health plans operating in Marion and Polk Counties.[6] There also were about 110 Primary Care Case Management (PCCM) contracts. The providers we interviewed included two pediatricians (both from the same pediatrics practice); an otolaryngologist; a clinic director; administrative staff of an FQHC; and administrative staff from Salem Hospital.

Salem Hospital is a voluntary community hospital with licensed capacity of 454 beds but an average daily census of 209. The hospital has established an urgent care center adjacent to the main hospital to divert non-emergency care from the hospital emergency room as well as to augment primary care capacity in the Salem area.

The city has had a long-standing shortage of medical providers, particularly in the area of family practice. Some Salem physicians attribute the shortage to problems of limited office space, competition with the more metropolitan city of Portland, and Salem's traditionally non-aggressive recruitment. Almost all of the physicians in Salem belong to the Mid-Valley IPA, which is described below.

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[6] As of July 1997, only four plans enrolled members in Marion and Polk Counties. QualMed and PacifiCare terminated their contracts with OHP in 1996. InterCommunity Health Network no longer enrolls members residing in the Salem area.

The West Salem Clinic is one of two FQHCs in Marion County. It also is a member of the Mid-Valley IPA. West Salem Clinic is affiliated with HMO Oregon and ODS through its membership in the Mid-Valley IPA. In addition, it is affiliated with QualMed on a fee-for-service basis with a risk incentive withhold and with CareOregon on a capitated basis.

It is important to recognize that the provider shortage in Salem predated OHP. In fact, during the 1915(b) Medicaid managed care program, HMO Oregon created a nurse practitioner (NP) clinic to build additional primary care capacity in the area.

7.2 The Establishment and Evolution of IPAs in the Three Communities

One of the striking impacts of the diffusion of managed care in Oregon, stimulated in part by OHP, has been the growth of local IPAs. In all three communities, physicians are organized in local IPAs, as a vehicle for increasing negotiating power with managed care organizations.

Each of the three IPAs includes all (or almost all) physicians in the community. The IPAs act as the contracting agent and fiscal intermediary for members. The IPAs serve as an intermediary between the health plans and the individual medical practices, highlighting the several layers of financial incentives that exist within OHP. Incentives are created between: (1) OMAP and the health plans, (2) the health plans and the IPA, (3) the IPA and the medical practices, and (4) the medical practices and individual physicians. Ultimately, the incentives faced by individual physicians should have the most impact on the cost and

use of care and the health outcomes of beneficiaries. However, these incentives are the most distant, the most diverse, and the most difficult to measure.

Hood River. Physicians in Hood River formed an IPA about two years ago in response to the imminence of OHP and managed care more generally. An IPA was forming in The Dalles, but competition between physicians in the two small communities did not seem reasonable; therefore, they joined together to form an IPA. All physicians in Hood River belong to the IPA.

Having no experience with contract negotiations, the newly-formed IPA hired an independent consultant and decided to contract with established and experienced plans. Subsequently, the IPA obtained OHP contracts with ODS Health Plan and HMO Oregon. Another contract with CareOregon was considered but was rejected in favor of plans with more competitive reimbursement rates, lower administrative fees, and (according to one source) a $10,000 bonus for signing. The IPA employs a part-time assistant, pays the Board members for attending meetings, pays a monthly stipend to officers, pays for consultant and attorney services, and pays the insurance for the IPA. Although OHP was the impetus for the creation of the IPA, it is no longer the sole contract. The IPA has commercial contracts with HMO Oregon and QualMed, and is negotiating with all potential third-party payors to expand the scope of its contracts.

Through the IPA, subcapitated pools were established for hospital care, primary care, specialty care, and miscellaneous services (equipment, pharmacy, home health). For OHP

members, hospitals are paid on a fee-for-service basis with a withhold. The Hood River and The Dalles hospitals are pooled together.

The IPA suffered major deficits in its first year, having spent more than the 10 percent withhold pool. However, under the arrangements with HMO Oregon and ODS Health Plan, the IPA was not financially responsible for overspending. Possible reasons for the large deficit were suggested by physicians that we interviewed[7]:

1. There was no real incentive to manage patients since physicians were not truly at risk.

2. In the first year there was unprecedented demand. Current Medicaid eligibles did not immediately roll over to OHP, and therefore, the IPA was seeing only new eligibles with high levels of unmet need and pent-up demand.

3. There was a small risk pool due to the relatively small numbers of OHP members in the community (about 1,200 people). There were major deficits primarily for inpatient hospitalization (especially surgery) and for radiology.

Roseburg. In Roseburg, OHP served as the catalyst for the IPA to develop its own prepaid health plan to contract directly with the State. In contrast to Hood River's approach of hiring consultants and contracting with experienced health plans, Roseburg developed its own prepaid health plan. The doctors wanted to contract directly with the State, rather than subcontract to a private managed care organization, and thereby eliminate the "middleman." RHEI pays its own claims so that the medical leadership has timely access to the data. RHEI has done so well under OHP that it is also seeking commercial contracts. The health plan is

[7] A fourth possibility is the high level of start-up costs for the IPA.

now known as SureCare. Roseburg's success has spawned the creation of other regional IPAs which are seeking OHP and/or commercial contracts to eliminate the "middleman."

RHEI was formed on a low budget basis with each physician investing $7,000. RHEI spent little money on advertising. Flyers were printed and distributed through area schools and churches. The member handbook was printed inexpensively, and, at the time of our visit, RHEI was just beginning to consider publishing a member newsletter. RHEI's administrative cost ratio was reported to be just 9-10 percent.

RHEI is a "pioneer" in its expanding use of subcapitation. RHEI began by capitating its primary care providers and executing a single capitated contract for urgent care services. Additionally, RHEI has capitated inpatient hospitalization and laboratory services (both within-office and out-of-office). OHP members are required to select a hospital (either Douglas County or Mercy), and that hospital is capitated for all hospitalization, including tertiary care referrals. RHEI chose to broaden capitation, in part, to reduce the capitalization requirement and minimize the stoploss insurance costs associated with fee-for-service risk. Whereas the State had formerly taken 5.6 percent of the premium for stoploss, RHEI was able to buy commercial stoploss for just 1.6 percent once the inpatient risk was gone. In contrast, the within-office laboratory component was capitated to PCPs due to the excessive billing by some providers.

After 30 days, all RHEI members are assigned a PCP if they have not chosen one. The PCPs especially are pleased with RHEI and strongly supportive of OHP. RHEI told us that, in the beginning, some physicians did not like the idea of taking the stipulated

minimum of 150 patients. Now, many are asking for more OHP patients. RHEI said that PCPs had been getting only 38 cents per dollar billed under traditional Medicaid, compared to 75 to 80 cents per dollar currently. The reimbursement is perceived to be somewhat better than Medicare.

Neither specialists nor hospitals, however, enjoy a similar financial advantage. According to RHEI, their payment rates are similar to those paid under the former Medicaid program. One specialist noted that RHEI has longer delays in payment. RHEI told us that some specialists have been resistant to the introduction of gatekeeping. Indeed, one specialist felt that the gatekeeping physicians were going to extremes in limiting the number of specialty referrals. He complained that he was not getting paid for some self-referred services because RHEI considered them to be included in the PCP's capitation.

Salem. The Mid-Valley Independent Practice Association (IPA) is the main vehicle for physician participation in OHP and commercial managed care programs in Marion and Polk Counties. Its membership includes about 390 physicians in about 110 medical practices, accounting for about 98 percent of all physicians in the two counties. All IPA members participate in managed care programs through contracts with health plans negotiated by the IPA.

For OHP, the IPA negotiates a fixed annual budget with both HMO Oregon and ODS. The IPA then pays its members on a fee-for-service basis, with a portion of the fee withheld as a performance incentive. The IPA uses the same reimbursement mechanism for its commercial contracts. Although the managed care plans contract with the IPA rather than

with the medical practices directly, the practices still must obtain prior authorization for certain services from the health plans and contact the plan directly to verify enrollment and PCP affiliation for OHP beneficiaries.

7.3 Impact of OHP on Provider Practice Patterns

Discussions with public and private providers within the three communities focused on the impact of OHP on provider practice in the following areas:

- provider participation,
- financial status of providers,
- diagnosis and treatment practices,
- emergency room use,
- administrative procedures, and
- performance monitoring.

7.3.1 Impact on Provider Participation

Anecdotal evidence suggests that the Oregon Health Plan has increased provider capacity by attracting physicians who previously did not participate in Medicaid or by expanding the Medicaid caseloads of those who did participate previously. One physician in Hood River, for example, volunteered that he agreed to accept 100 OHP families into his practice -- a number which he estimate to be his personal responsibility under a "fair share policy." In Roseburg, some physicians initially did not like the idea of taking the stipulated minimum of 150 patients. Now, many are asking for more OHP patients.

Providers also indicated they were expanding office hours to better serve OHP enrollees. In Hood River, most after-hours care prior to OHP was provided by the hospital

emergency room or local urgent care center. The office practices as well as the FQHC have expanded evening hours and weekend coverage, while the Hood River Memorial Hospital is establishing an after-hours clinic to help address costly ER utilization.

As a result of increased provider participation in Medicaid, many beneficiaries reportedly shifted their usual source of care from the local health department, an FQHC, the hospital ER, or perhaps they acquired a usual source for the first time. In Roseburg, for example, the health department has discontinued its well child clinic because private providers are now delivering this care under OHP. In Hood River, the health department has observed a sharp drop in the number of well child care exams it provides, from about 200 per year to 35 per year, limited mostly to camp and school physicals.

One physician reported that the major impact of OHP on patients has been to shift the expansion population from crisis care to preventive care. Parents are eager to obtain a regular doctor for their children. Doctors suggested that, under OHP, families feel more responsible for the health of their children because they now have choices of both public and private providers.

Initially, lack of provider capacity was a problem in Salem that stemmed from longstanding shortages of primary care providers (PCPs) in particular. The lack of providers was well-documented early in OHP when a local consumer advocacy organization called physicians to determine which practices were accepting new OHP patients. The advocacy group telephoned 80 of the 120 physicians advertised as participating OHP providers (excluding physicians affiliated with KaiserPermanente), and asked to be seen as new

patients. Of the 80 PCPs contacted in the area, 40 practices placed the advocacy group on hold for more than five minutes (after which the group disconnected), and the remaining 40 practices reported that they could not sustain an increase in patient load irrespective of a patient's source of insurance. Several initiatives were undertaken in response. First, the capacity of the Salem Clinic was expanded. The clinic was established by HMO Oregon during the 1915(b) program due to lack of provider capacity and was staffed exclusively by nurse practitioners. The clinic hired a physician medical director as well as several physician assistants and was also attempting to recruit additional physician staff. A second initiative involved linking ER users with PCPs if they were unassigned. Thus, OHP patients who presented at the ER in Salem and who had no PCP were assigned to local physicians on a rotating basis. This procedure effectively shifted frequent ER users to a PCP. As an example, pediatricians described a family who routinely used the ER twice a month for a child who was experiencing unexplained fainting spells. Following an inpatient admission through the ER, the child was assigned to a pediatrics practice and now has a PCP whom the parents contact whenever they need advice about this child's health. The family no longer uses the ER as a provider of first resort.

Salem Hospital also has observed an increased willingness on the part of specialists to treat OHP enrollees. Salem Hospital historically has encountered some resistance to treating Medicaid beneficiaries among specialists on its staff; however, the problem has diminished under OHP. The problem varies by specialty, appearing to be greatest among orthopedists.

7.3.2 Impact on Financial Status of Providers

Private Physicians. Most private physicians felt that the eligibility expansions under OHP had beneficial impacts on their practice. Expansion of insurance coverage among the previously uninsured tended to improve the financial status of physician practices (by reducing bad debt and uncompensated care). PCPs in Salem indicated that OHP has had a positive financial effect on their practice as a result of the fee increases for the categorically eligible and the expansion of eligibility to the uninsured, whom they previously saw without charge. They do not perceive, however, that their caseloads have increased.

Hospitals. One measure of the impact of increased insurance coverage is the diminished demand for charity hospital care with the advent of OHP. The hospital in Hood River, for example, has a goal to provide 1 percent charity care per year. They are providing less charity care and have fewer applications since the implementation of OHP. In situations involving below the line services, the hospital first bills the patient and then encourages them (if they are unable to pay) to apply for charity care.

FQHCs. In contrast to reports by private providers, both of the FQHCs we interviewed felt that OHP had hurt their financial position due to the loss of cost-based reimbursement for Medicaid clients and other factors. The West Salem Clinic was especially dissatisfied with their contract with CareOregon. For example, they noted that CareOregon instructed OHP beneficiaries who live in outlying areas to use the nearest emergency room if transportation to West Salem Clinic is unavailable. The ER use was then billed to West

Salem Clinic. As another example, they felt that the participation of Oregon Health Sciences University (OHSU) in CareOregon resulted in adverse selection for West Salem Clinic. Marion and Polk County residents who have been seen routinely at OHSU in Portland for severe health problems were told to choose West Salem Clinic as their PCP. When the OHSU specialist called for a referral so that the patient could continue to be seen at OHSU, the referral was provided by CareOregon (not by the clinic). Although West Salem Clinic receives the monthly capitation, for which it delivers essentially no service, the revenue is more than offset by losses from the annual withholding pool as a result of services delivered at OHSU.

Neither of the FQHCs felt that the eligibility expansion compensated for the elimination of cost-based reimbursement (LaClinica reported a 50 percent reduction in per visit payment). Despite the eligibility expansion, neither FQHC has observed a measurable change in the mix of insured and uninsured clients. The director of LaClinica cited several reasons for the high level of uninsured clients, including the mobility of their population, language barriers, and more recently, the need for three months of income to define eligibility. The three-month income averaging has been particularly problematic for La Clinica clients, many of whom are seasonal workers. During the 5-month harvest season, the sudden burst in income disqualifies workers from OHP, although they would be eligible during the other seven months. Thus, they tend not to be eligible during the months they are working and their health care needs are the greatest, but rather only when they are not working. (During these months of high use, the FQHC would not be receiving the capitation

payment.) As OMAP notes, for seasonal workers, "timing is everything" in the application process. The incentive is to submit the application when the average of current-month and the previous two months of income would qualify. Then, the individual or family is eligible for the next six months. Nevertheless, there may be some months during the cycle in which the individual or family will not qualify, resulting in a lapse of coverage until average income is low enough.

The FQHCs noted other unanticipated financial consequences resulting from OHP. La Clinica is a designated OHP eligibility outstation; the outstationed eligibility worker previously was included in the FQHC cost-based reimbursement and continues on the clinic payroll. Although the State is supposed to pay reasonable expenses for the worker, those expenses have yet to be defined, and no State employees are assigned to deal with this issue. Additionally, requirements for three months of income documentation have burdened their existing copying capacity, necessitating the purchase of an additional copy machine.

7.3.3 Impact of the Priority List

Most providers favor the priority list because they see it as a factor in extending health insurance coverage to more persons. Moreover, providers in the three communities felt that the priority list was having little effect on the practice of medicine. Most diagnoses and treatments that should be covered were covered by OHP at the time of our visit.[8] Other treatments, involving symptomatic relief, were readily available over-the-counter.

[8] However, since our site visit, the line has moved twice from line 606 to line 581, and then from 581 to 578. Future analyses will examine the impact of the further restriction of covered services.

Nevertheless, providers identified a number of ways in which the priority list has affected their practice.

Uncovered Services. Most physicians have attempted to learn which services are covered by the priority list and which are not. However, most providers would acknowledge there has been a steep "learning curve." A fair amount of experience was needed to match condition and treatment pairs. Additionally, some diagnoses and treatments do not have matched pairs, and others have guidelines that are not integrated into the priority list. Staff have found the State's nurse benefit hotline to be helpful. The nurses help determine what is covered and answer coding questions (See Chapter 5).

Administration of the priority list has introduced a number of new complexities into physician practice. Although diagnosis of a below-the-line condition is covered, treatment is not. A new problem is the phenomenon of being able to diagnose but not treat certain illnesses, as in the example of hernias. Furthermore, if a patient is not better in a few days, providers cannot see *and bill* for an additional office visit unless there is a new diagnosis. An example is low back pain (back strain); providers generally diagnose and make recommendations for another appointment in 6-8 weeks. Now patients must call to say that they are worse for the provider to re-evaluate. Some providers feel that they proceed to diagnostic studies at an earlier stage than before OHP.

The FQHC in Hood River has attempted to alert patients to potential below-the-line services even before an appointment is scheduled. The appointment schedulers use a computer program to do pre-screening over the phone about conditions that fall below the

line. The worker tells the patient when a condition might not be covered. La Clinica staff seemed particularly concerned about the impact of the priority list with regard to coverage of colds and flu (which are below-the-line). The FQHC staff provide a lot of education about nasal hygiene and recommend over-the-counter remedies. They also educate and warn parents to refrain from giving aspirin to their children because of the risk of Reye's syndrome. They are not compensated for this patient education and thus employ the sliding scale to bill the patient.

Providers identified certain services that were uncovered, but which they felt should be covered. For example, a hospital CEO complained that OHP pays for lung transplants but not smoking cessation.[9] As another example, in the Hood River area, there is a high incidence of allergies, especially among farm workers (probably pesticide-related) which result in a rash and swollen eyes and face. A single Kenalog shot would result in almost immediate relief but has been denied to OHP patients because it is below the line.

For uncovered services, physicians can seek a waiver for reimbursement on a particular case. For example, one young schoolgirl had warts on her hand which were spreading and would become irritated from rubbing while she wrote. The doctor's office sought a waiver from the health plan. The wart therapy was approved since there was a risk of infection.

[9] This "inconsistency" has now been rectified. OHP now pays for both nicotine patches and counseling to promote smoking cessation.

There are some objections to the lack of coverage for low-grade pain complaints. Although such conditions typically are not unbearable to the patient, sometimes they pose serious problems. In one practice, a patient with severe torticouis (neck muscle constriction) was treated despite the knowledge that the service fell below the line on the priority list. The practice sought an exemption from the health plan in order to receive reimbursement for the care provided. Practices find that such appeals for reimbursement of a noncovered service are often approved if the treatment is clearly important and necessary.

Physicians reported that there generally is no linkage between prescription drugs and the priority list, so that prescriptions will be covered even if they are written for noncovered services. RHEI intended to deny coverage of prescription drugs for low back pain, for instance, but at the time of our visit, the health plan had not yet implemented edits to identify drugs prescribed for below-the-line conditions. In contrast, laboratory coverage is limited to tests associated with covered services.

Provision of "Free" Care. Physicians reported that they deliver a significant amount of free services because of the large number of conditions not covered, and therefore, not reimbursed. One physician told us that it is simply too much work to figure out what falls above or below the line. Providers and health plans noted that the capitation rate was generous enough to accommodate delivery of uncovered services.

Often, the decision to provide free care is made on a case-by-case basis. One physician reported that he routinely refuses to treat minor warts for OHP patients because

it is below the line. However, he will treat a wart that has potentially significant consequences (e.g., a large facial wart on a teenager) despite the lack of coverage.

RHEI has distinguished itself by performing hernia operations for free. RHEI had developed criteria for hernias but then discarded them because of provider dissension. In response, the surgeons and hospitals donated the time and set aside one or more Saturdays a month to perform hernias free of charge. RHEI also has paid for the removal of warts and treatment of lower back pain.

Specialist Concerns. Specialists are less comfortable with the priority list than PCPs since the list is designed to be generous with primary care services and less so for specialty care. For example, a general surgeon in Hood River complained that hernias and hemorrhoids were not covered, while the ENT complained about tonsillectomies not being covered. Hospital administrators have received few complaints from clinicians or patients about uncovered services because most are encountered before the patient reaches the hospital. The most notable exceptions concerned hernia and pharyngitis. However, for any ER services which are below-the-line, one hospital requires patients to sign a waiver recognizing that they are responsible for a payment arrangement. The hospital bills the patient for all uncovered visits, including those below-the-line.

Coordination between PCPs and specialists has been particularly challenging. ODS permits PCPs to refer to specialists to rule out a specific problem. However, the diagnostic code on the specialist's claim must match the code on the PCP's claim for the specialist to

be reimbursed, even if the specialist diagnoses a different condition. To be paid, the specialist must retain the original diagnostic code even if it is inaccurate.

One specialist reported significant problems with the priority list involving the division of coverage for diagnosis and treatment. In his practice, three-fourths of tonsillectomies for chronic tonsillitis were performed on children under 100 percent FPL. Since this service is no longer covered under OHP, they have lost reimbursement for a significant activity. Furthermore, they no longer have the opportunity to diagnose more serious problems in children with tonsillitis because the children are rarely referred.

Changes in Coding Practices. One of the most interesting impacts of the priority list reported by physicians is the change in coding practices. Two types of changes were reported, one which improves the value of codes for health services research and one which degrades it. Physicians reported that in the past very little attention was paid to the codes because virtually everything was covered. In particular, very little attention was paid to which subcategory (e.g., fifth ICD-9 digit) was used. Now, coverage often depends on the fifth digit and so coding practices have been tightened. For example, acute bronchitis is above the line but chronic bronchitis is below the line. Thus, it is now important to make the distinction at the fifth digit. The Salem IPA trained the practices' business managers on proper coding procedures, with the participation of staff from OMAP and HMO Oregon.

Although the greater scrutiny given codes may have caused an increase in precision of coding, it has not necessarily increased the comprehensiveness or accuracy. One physician reported that, in the past, he tended to include on the claim as many conditions as

he found (up to the maximum number of fields). But under OHP, he discovered that if most of the secondary codes were not covered, the claim would be denied, even if the primary code was covered. In response, he no longer codes all conditions and limits the codes only to the ones that are covered. As a result, accuracy of coding may decline in order to accommodate inconsistencies in the priority list. For example, acute sinusitis is covered while chronic sinusitis is not covered, except for surgery. The decision to operate depends on a preliminary visit for chronic sinusitis that is not covered (because there was no surgery involved). Consequently, providers reported that they code acute sinusitis until the day of the surgery, at which time the diagnosis becomes chronic sinusitis.

7.3.4 Impact on Emergency Room Use: The COBRA "Catch-22"

In each of the three communities, hospitals and physicians expressed concerns about the fundamental inconsistency between managed care pressures to reduce emergency room (ER) use and the provisions of the Federal COBRA "anti-dumping" protocols. COBRA requires that patients presenting at an ER be triaged by a physician. Three hospitals were cited for COBRA violations due to inadequate screening and diagnosis by a physician.

In two of the communities, the hospitals have responded by establishing urgent care centers to provide after-hours care for non-emergent patients. All hospitals also have responded by improving screening procedures for patients who present at the ER, regardless of whether they have true emergencies or not.

PCPs also feel they face a "catch 22." They have found it very difficult to deny ER visits over the telephone, because the problem is always urgent in the patient's mind. Denial of an ER authorization may leave the physician open to liability in the event of an adverse outcome. This is exacerbated by hospital concerns over the COBRA rules.

At Hood River Memorial Hospital, every patient who presents for emergency care first is screened by a physician (for a preliminary diagnosis) and then their insurance is checked. If necessary, the PCP is called to see if the visit is authorized. If the visit is not authorized, the patient is given a choice either to wait to be seen by the PCP or to pay for the visit out-of-pocket. The health plans now have negotiated a $15-25 triage fee to cover the costs of a physician screen (essentially to make a diagnosis). The administrator of the Hood River Memorial Hospital complained that triage fees do not nearly cover the actual costs involved.

The Hood River ER feels heavily burdened by the financial responsibility and is developing a 24-hour urgent care program (known as PromptCare) to help ease unnecessary ER use. The PromptCare clinic offers the same non-emergent care often provided at ERs but at clinic prices rather than the more costly ER fees. At first, local physicians were fearful of the competition which PromptCare might present to their practices, but such apprehension has quickly grown into appreciation for the option of after-hours coverage. The PromptCare clinic staff are still trying to understand how best to deal with the nuances of COBRA and are in the process of developing triage guidelines to assist nurses in distinguishing between ER and clinic patient situations. Although the hospital

would like to employ the same person to greet both emergency room and urgent care patients, they cannot since the law specifies that the two must be separate. Such a requirement is both costly and frustrating to the hospital. This problem is not specific to OHP but to managed care in general. According to the administrator of the Hood River hospital, decreases in ER volume and inadequate reimbursement for ER doctors within a managed care system are creating financial pressures on the hospital ER that are exacerbated by COBRA restrictions.

In Salem, patients who present at the ER are screened to determine if they have an emergency problem. The PCP is contacted to determine whether the patient should remain at the ER. If not, and the hospital staff believes ER care is necessary, they will treat and negotiate for authorization after the fact. The PCP has to authorize inpatient admissions through the ER and the health plan must be notified within 24 hours. Before OHP, the hospital needed prior authorization to admit all Medicaid patients; now they require it only for non-emergency cases. All affiliated health plans have agreed to authorize the admission of anyone who meets the COBRA emergency screening criteria.

Salem Hospital was cited for COBRA violations. The hospital was fined $50,000 for referring a child to OHSU without proper documentation. In response to managed care pressures as well as COBRA concerns, Salem Hospital opened an urgent care center adjacent to the hospital. Staff believe that the urgent care center is attractive to persons who would not have bothered with the hospital's emergency room for a condition that was not a true emergency. Some health plans routinely authorized use of the urgent care center and Kaiser

has contracted with the hospital to use the center for after-hours coverage. The popularity of the clinic is also attributed to the longstanding shortage of primary care physicians in Marion and Polk Counties. About 40 percent of the patients who use the urgent care center are OHP members. The number of visits to the ER (including the new urgent care center) increased 11 percent in the past year, due to an increasing reliance on the urgent care center for after-hours coverage and urgent care.

RHEI has achieved substantial savings by denying payment for unnecessary emergency room visits. Douglas County Community Hospital alone dropped 250 to 300 emergency room visits per month. Both Douglas County Community Hospital and Mercy Medical Center had been working proactively with RHEI to triage nonemergent ER patients to more appropriate PCP settings. However, in response to a patient complaint, both hospitals were investigated for illegal "dumping" by HCFA regional staff. The two hospitals were cited for COBRA violations, and Mercy was fined. HCFA apparently defines an *emergency* more broadly than RHEI does. To avoid further difficulty, Douglas County Community Hospital entered into a capitated arrangement to provide after-hours urgent care. The hospital now simply directs non-emergent patients to its urgent care clinic. Mercy, on the other hand, chose not to pursue this arrangement. For the time being it is seeing and treating all ER patients whether or not RHEI pays.

The COBRA enforcement action has resulted in new measures to prevent future citations. One physician indicated that he now has to fill out three forms to discharge someone from the emergency room. Moreover, he was sanctioned for referring a patient to

a community provider for urgent but nonemergency eye surgery. He explained that he felt the procedure in question did not necessitate emergency room treatment, especially when it could be done on a timely basis by someone specifically trained to do it.

7.3.5 Impact on Administrative Procedures

All providers have experienced problems with increased paperwork burden due to eligibility/enrollment verification and referrals; and since each plan has its own processing requirements, interactions between providers and plans can be confusing. Previously with OMAP alone, office staff were able to keep abreast of any changes in policies, procedures, and paperwork. With the advent of OHP and multiple participating plans, there is a need for an insurance specialist (a full time staff person with training in insurance) in the office. It should be noted that some office staff believe that the problems are not with OHP specifically, but rather, with managed care in general.

Paperwork Burden. Office staff feel the major stumbling block to OHP is the quantity of paperwork they have to perform. They would like to see standardization across plans, in terms of referral and billing processes, standardization of forms, and standardization of insurance cards (i.e., standard codes and formats).

The PCPs we interviewed report that denial of payment due to loss of eligibility and changes in health plan or PCP enrollment has been common. Most beneficiaries do not understand the need to reapply for OHP eligibility; however, if they get past their six-month recertification, the problems begin to decline. Nevertheless, providers must verify OHP

eligibility, health plan enrollment, and PCP affiliation at every visit in order to avoid denials -- a process they find burdensome, despite the fact that HMO Oregon has placed an on-line terminal in provider offices for this purpose. However, West Salem Clinic reports that the eligibility data are not always current; beneficiaries have until the sixth of the month to make PCP changes retroactive to the first of the month and the HMO Oregon database is not updated until mid-month. Beneficiaries do not always arrive at West Salem Clinic with their OHP card. West Salem Clinic staff report that these eligibility and enrollment verifications usually take from 45-60 minutes per patient, which they see as a serious burden.

Specialty Referrals. Office staff expressed frustration with the amount of time it takes to make referrals. Substantial time is spent by office staff in calling the patient's plan to get the patient's referral number required by the hospital after a physician authorizes an outpatient visit. Staff members may be placed on hold for 20 minutes, after which the only response may be a pre-recorded message. Only rarely do they speak to an actual service representative. Leaving a message through voice mail appears to be effective; however, getting through is not guaranteed. Wait times for referral number requests can average 2-3 days, making the entire process extremely time consuming.

7.3.6 Impact on Performance Monitoring

Physicians expressed serious concerns about the lack of data received from health plans on physician performance in OHP. This has been one of the motivating factors in the

development of local or regional IPA plans that want to provide more accountability for financial and clinical performance.[10]

In Hood River, no meaningful information regarding expenditures, utilization, or quality of care was being filtered down from the health plans to individual physicians or the hospital. As a result of this lack of feedback, there is little if any external incentive to manage care. There have been no communications with, or sanctions from, the health plans about financial or other performance. The IPA would like to see monthly statements on revenues, utilization, costs, and balance within each of the subcapitated pools.[11]

The health plans are responsible for quality assurance activities, but the IPAs would like to take on this responsibility. Since each health plan is responsible for quality assurance and the IPA contracts with several health plans, IPA members are potentially subject to several sets of quality assurance procedures and standards, which they find burdensome. As an alternative, the IPA in Salem is developing its own quality assurance program for which it is seeking NCQA certification. The health plans would then seek approval from their funding sources (OHP and commercial clients) to delegate the QA responsibility to the IPA's certified program. Then the medical practices would participate in only one set of reviews for all health plans and physicians would presumably find it more

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[10] As another example, the Lane County IPA is considering withdrawing from HMO Oregon, due to lack of feedback on financial and clinical performance.

[11] Future site visits will examine whether the health plans have begun to share more data with the IPAs, or whether lack of feedback remains a concern. In addition, the physician survey will assess whether this is a localized or statewide problem.

palatable to be reviewed by their own membership organization, the IPA, than by various health plans and insurance companies.

7.3.7 Summary of Common Themes

A number of common themes emerged about the impact of OHP on providers. First, there was consensus that the priority list has not had a major impact on physician practice. To date, physicians have found ways to provide care that they feel is necessary, either by obtaining exemptions from the health plans, or by providing care free of charge (e.g., hernia days in Roseburg).

Second, there is a widespread perception that access and capacity has improved, especially for the expansion population. The managed care structure, together with the higher fees that encouraged provider participation, were critical to the success of OHP in improving access to care. Physicians feel that OHP's increased reimbursement rates alone would not have achieved the positive outcomes. In Roseburg, physicians initially sought to limit the number of new OHP patients, but now, will take as many as are available. Physicians praised the improvements but acknowledged that the population which remains uninsured continues to face barriers.

Perhaps the most vocal concern raised by providers was related to the provision of after-hours care. In two of the communities, hospitals had been sanctioned for violation of COBRA "anti-dumping" provisions. Providers in all communities noted a fundamental conflict between COBRA's requirements for *physician* screening of all ER patients and an

unwillingness of managed care plans to compensate adequately for the costs of triage. This is perceived as an irreconcilable "catch-22" that has profound financial and liability implications for the hospitals. Hospitals have responded by establishing urgent care centers to which they can triage non-emergent patients. But this is viewed as only a partial solution, because a physician still must screen anyone who presents at the ER prior to triage.

An important implication of the community case studies is the differential reaction to OHP between the private providers and public agencies. The private practice physicians and the local community hospitals strongly favor OHP, seeing it as a way to improve the coordination of care for persons who in the past had few, if any, resources available for health care. Moreover, many physicians reported that reimbursement rates have increased, even though the overall volume of patients has not increased in all cases. The net effect is an improvement in their financial status.

In contrast, the community-based providers that we interviewed -- the FQHCs and other clinics -- tended to be wary of managed care under OHP and reported problems working with the health plans. These providers reported significant financial losses due to one or more factors, such as decreased reimbursement rates, adverse selection, loss of patients, or significantly higher administrative expenses because of the lack of standardization in policies and procedures across health plans. These losses occurred despite increased payments for previously uninsured individuals. Loss of patients may be a consequence of increased accessibility to providers who previously were not participating in Medicaid.

A number of caveats apply to any case study of program impacts. First, the findings are anecdotal and not empirical. Second, the results are not necessarily generalizable to the provider population as a whole. In particular, results may be biased favorably (or negatively) if those who agree to be interviewed are more positive (or negative) toward the program than the population as a whole.[12] Third, the results represent a snapshot at one point in time. Changes have occurred since the interviews were conducted that might affect the attitudes and opinions today.[13] Finally, the reliability of the analysis is dependent on the honesty of the respondents in sharing their experiences and presenting a balanced picture of how the program is working.

Future site visits will follow-up on the themes identified in these provider case studies, and hopefully extend the investigation to additional communities (especially in Eastern Oregon). Moreover, the provider survey, which will include more than 1,000 physicians and agencies, will obtain quantitative estimates of provider reactions to OHP, and how the program has affected their practices. Special attention will be given to the impact of OHP on providers who treat people with disabilities.

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[12] We interviewed the universe of FQHCs, public health departments, and hospitals within the three communities. Thus the major potential source of bias would be due to a non-random selection of physicians.

[13] For example, as of January 1996, the cut-off line on the priority list was raised another 25 items. However, subsequent communications with physicians suggest that attitudes and experiences have not changed substantially.

8 Impact of the Oregon Health Plan on Consumer Access: Preliminary Impressions

The Oregon Health Plan (OHP) was designed to improve access for traditional Medicaid enrollees by: (1) increasing Medicaid fees as an inducement to provider participation, and (2) accelerating the growth of private managed care to bring new providers into the program. The OHP eligibility expansions were designed to remove financial barriers to care experienced by the low-income uninsured who were categorically ineligible for Medicaid.

The provider case studies presented in Chapter 7 suggest that access and capacity have improved. Consider the following evidence. New physicians were brought into the program, especially with the recruitment of physicians to serve as primary care case managers (PCCMs). Providers opened their practices to more patients beyond their original commitments. Providers expanded their office hours to accommodate demand. New clinics were established to deal with urgent care needs or to address historical provider shortages. Patients who historically used the emergency room were being assigned to primary care providers.

Most of our current impressions about the impacts of OHP on access to care are based on anecdotal evidence, through case study interviews and analysis of secondary sources. Empirical information is not yet available from the evaluation. Thus, this chapter reviews preliminary impressions of the access impacts, drawing on secondary data where

available. We highlight findings in several areas. We examine how OHP has affected the traditional Medicaid population who shifted into managed care, based on: (1) preliminary analyses of client satisfaction with the accessibility of care; and (2) preliminary data on the use of preventive care among newly-enrolled women. Both of these data sources suggest favorable impacts of OHP on access to care, based on self-reported information from beneficiaries.

We also review anecdotal evidence concerning access to maternity care and access to dental care. Here, the State and managed care plans have faced greater challenges, which is to be expected in a program that absorbed so many new eligibles so quickly, expanded benefits dramatically (especially in the case of adult dental care), and had not anticipated the challenges in linking private providers with community-based services (e.g., maternity case management). Our goal in presenting these two implementation case studies is to demonstrate the challenges faced by the State, and the initiatives undertaken in response.

Finally, we consider an "unintended consequence" of OHP, namely the spillover effects onto those who remain uninsured. Fewer resources may be available to the "near poor" who are not eligible for OHP, yet who remain without health insurance coverage.

8.1 Client Satisfaction with Access to Care

The State conducted baseline and follow-up surveys to assess client satisfaction with the medical care they received prior to OHP implementation and about two years into the

program (OMAP, 1996).[1] The results indicate that overall satisfaction increased within the Phase I population that shifted from traditional Medicaid into managed care. For example, OHP eligibles were more likely to be satisfied with their ability to get medical care whenever it is needed (70 percent in 1994 versus 88 percent in 1996). Moreover, satisfaction with the choice of primary care providers improved (59 percent versus 69 percent). Three-fourths (75 percent) feel they are better off now than before OHP. These findings suggest that Phase I clients (in the aggregate) are more satisfied with their access to care under OHP -- with the shift to managed care and the prioritized list of benefits -- than under the traditional Medicaid program.

8.2 Access to Preventive Care

A recent study by the Oregon Health Division, in collaboration with the Office of Medical Assistance Programs (OMAP), suggests that OHP has improved access to preventive care among newly-enrolled women (Oregon Health Division, 1995b). Funded by the Centers for Disease Control, the study involves two waves of telephone interviews with a random sample of 515 women ages 52 to 64 who were newly enrolled in OHP between February and December 1994. The baseline survey was conducted in January and February 1995 and gathered information on breast and cervical cancer screening prior to enrolling in OHP, general health status, major diseases, tobacco use, knowledge and attitudes

[1] The baseline survey was fielded in January 1994; 5,655 surveys were completed with a 36 percent response rate. The follow-up survey was fielded in January 1996; 11,591 surveys were completed with a 63 percent response rate.

about preventive care, and prior health coverage. A follow-up telephone survey was conducted in late-1995. Preliminary results are available on approximately half of the original sample.

The baseline survey revealed that women enrolling in OHP were far less likely than the general population to ever have had a mammogram prior to enrollment. Whereas 11 percent of all Oregon women in the age group had never had a mammogram, fully 42 percent of the OHP enrollees had *never* had a mammogram. Mammograms are recommended annually for this age group (Eddy, 1991). Over half of the women had not had health insurance for at least five years (including 16 percent who had never had health insurance), and one-third had not had a routine check-up for at least five years. These results are coupled with the finding that 44 percent had one or more of the following conditions: heart disease, chronic lung disease, high blood pressure, diabetes, or cancer.

One year later, after spending at least nine months on the Oregon Health Plan, 95 percent had visited the doctor or other medical provider; 65 percent of those who had not had a routine check-up in the previous five years had done so; 83 percent of women with diabetes had had a dilated eye exam in the previous year; and the rate of routine mammograms in the past two years doubled from 33 to 63 percent. This evidence suggests that the expansion of financial access through OHP, and perhaps the emphasis of managed care on preventive care, has resulted in increased rates of preventive care use within the target population of this study.

8.3 Access to Maternity Care

8.3.1 Background

The Oregon Health Plan's eligibility expansions do not apply to pregnant women since they were already covered up to 133 percent of the Federal poverty level under previous expansions.[2] The primary effect of the OHP on maternity care, then, has been to shift publicly-funded pregnant women into managed care plans.

Considerable publicity was generated as a result of a study by the Governor's Maternity Care Access Planning Commission on the adequacy of access to prenatal care following implementation of OHP.[3] The study documented a deterioration in the adequacy of prenatal care and an increase in the rate of low birth weight (LBW) infants. The study, however, was fraught with methodological limitations.[4] Nevertheless, the findings have focused attention on potential barriers to prenatal care with the shift to managed care.

The Commission called a meeting in July 1995 to identify possible causes of alleged poorer performance under OHP. Over 300 participants (including health plans) were invited. The meeting "uncovered a private sector straining to handle social problems affecting maternity care that had been fielded by public health in the past" (Morrissey, 1995).

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[2] OMAP notes, however, that many were not aware of this coverage. The increased visibility of OHP may have increased awareness of expanded eligibility for pregnant women.

[3] Adequate prenatal care was defined as care initiated in the first trimester.

[4] For example, statistical tests of significance were not done and possible confounders were not controlled for (e.g., maternal age, chemical dependency). There is concern, too, about attributing the impacts to OHP and managed care due to the lack of indicators related to OHP coverage and managed care enrollment. The State noted that there is some ambiguity in the definition of births by payor source because the source is self-reported by the birth mother. Publicly-funded deliveries can include illegal aliens who are ineligible for Medicaid or OHP prenatal care and are only qualified for coverage of delivery. Additionally, women covered under OHP may consider their coverage "private insurance" rather than "public coverage" which would change the mix of publicly-funded births and negatively skew the outcomes attributable to OHP.

Participants suggested that private providers faced challenges in handling the myriad social problems among pregnant women enrolled in OHP, such as their nutrition needs (WIC enrollment dropped 20 percent), homelessness, or language barriers.

It should be stated from the outset that not all providers feel access to prenatal care has deteriorated. For example, the Multnomah County Health Department reported that, if anything, women are getting in earlier. The health department's prenatal caseload has dropped because of OHP, which has eased their burden. Some private OB providers are, however, reluctant to start seeing a client until they are sure they are authorized to do so. In such instances, the Multnomah County Health Department will see the patient for the first visit while the client is on an open card, and bill OMAP on a fee-for-service basis. They have direct access to the OMAP eligibility database and can tell whether a patient is assigned and to whom.

Discussions with the State, local health departments, FQHCs, and providers revealed a number of maternity care issues that surfaced during the early months of OHP. The principal challenges faced by the State included: (1) expediting enrollment into managed care plans to facilitate early initiation of prenatal care, and (2) linking high-risk pregnant women to maternity support services.

8.3.2 Eligibility/Enrollment Issues

Prior to OHP, presumptive eligibility was authorized by the Omnibus Budget Reconciliation Act of 1986 as part of an effort to expand Medicaid eligibility for low-income pregnant women and to reduce delays in entering prenatal care. In the past, some women went to public health clinics, received free pregnancy testing, and were signed up for Medicaid immediately by the public health clinic. Enrollees could obtain prenatal care through public or private providers immediately upon determination of presumptive eligibility.

Enrollment in OHP, however, involves an application process. As part of the application, enrollees must choose a health plan and primary care provider (PCP). Delays in selecting a health plan or a PCP can result in delays in obtaining prenatal care.

OMAP recognized that the shift to managed care introduced unexpected barriers to obtaining early prenatal care. Initially, if a woman chose a PCP who did not provide obstetrical care, she would need a referral to an OB provider. In response to concerns about prenatal care access, PCP approval is no longer needed prior to an OB visit. Certified nurse midwifes may also serve as direct entry providers.

Other changes have been made to improve the eligibility determination process for OHP applicants. For example, more outstations for OHP have been posted at FQHCs and disproportionate share hospitals to help pregnant females fill out eligibility forms. Additionally, changes requiring 3-month documentation of income do NOT apply to pregnant women. Finally, the eligibility form was recently revised to ask, are you pregnant

at this time? The eligibility workers make every effort to process this group first (these applications are batched daily). If the woman does not choose a plan within 30 days, she is assigned a plan automatically. (At the time, this was the only group for which there was automatic assignment.)

8.3.3 Maternity Case Management

Another concern with the shift to managed care was the linkage of high-risk pregnant women with Maternity Case Management (MCM). Medicaid has funded MCM services since the late-1980s in an effort to improve maternity outcomes among high-risk pregnant women. Under OHP, MCM services can be provided by health plans under a capitated payment arrangement or can be accessed on a FFS "wraparound" basis. As of October 1, 1995, four plans (Good Health Plan, Intercommunity, QualMed, and Selectcare) began taking the MCM capitation fee. These plans are encouraged to contract with local health departments for MCM services, but this is not required for MCM services.[5] County health departments continue to be able to bill Medicaid directly for MCM services provided to clients not enrolled in one of the four plans capitated for MCM services.

Anecdotal evidence, reported by health departments, suggests that many high-risk women have not received a referral for MCM services from their prenatal care provider.

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[5] In contrast, plans are required to contract with local health departments for communicable diseases, STD treatment, and immunization because these services are included in the capitation rate. With MCM services (except in the four plans that are capitated for MCM services), OHP enrollees have free access to go anywhere, including the local health department, and OMAP will pay FFS.

Health departments may pick up cases through other methods of case finding, for example, through WIC, immunization, or well child clinics. If the program operates in a small community, where people know each other, it is likely that the health department can identify many of those at high risk. In such cases, the health department calls the prenatal provider and asks for a referral. In the Tri-County area and other urban areas, the health departments are attempting to connect more with the health plans than with the individual providers to obtain referrals.

When the county health departments get a referral from a provider, they call the health plan to obtain a formal referral (assuming there is a contract) and then the county can be paid by the plan. However, the number of visits is very limited, and often intensive case management is necessary because intervention did not occur early in the pregnancy. A total of four visits -- two prenatal and two postnatal -- are covered at $250-$400 per pregnancy. The MCM provider is supposed to address a minimum of two elements during each visit (based on OMAP guidelines); however, the health department generally provides more than the minimum level of care.

In short, the health departments believe that more provider and client education is needed to stimulate referrals. The State is undertaking a two-prong informational campaign -- one for consumers and the other for providers. In addition, most plans are now contacting pregnant women to initiate outreach, provide educational materials, and ensure that they are seeing their prenatal care providers. As the State notes, this never happened pre-OHP.

Two initiatives are being undertaken to encourage provider referrals for MCM services. In conjunction with the Oregon Health Division, OMAP was developing a comprehensive description of maternity case management, including the capacity, payment arrangement, and service plan. In addition, the State is supporting the development of a risk-screening tool to more systematically identify high-risk pregnant women. The State intends to contract with SafeNet in order to help providers obtain information regarding the availability of MCM services for their high-risk patients.

8.4 Access to Dental Care

8.4.1 Background

Oregon has had a longstanding shortage of dental capacity for Medicaid clients. A statewide oral health needs assessment in the early 1990s found that one-third of Oregon's counties had severe dental care access problems for Medicaid clients (Oregon Health Division, 1993).[6] Four counties had no active dentists. Exacerbating the need for dental care is the lack of community-based prevention efforts. Oregon has one of the lowest rates of fluoridated water supplies nationwide. Additionally, children have limited access to dental sealants to prevent tooth cavities.

Prior to OHP, the Medicaid program covered dental care for children. The OHP priority list expanded Medicaid benefits to include preventive, restorative, and emergency

[6] The twelve counties are: Clatsop, Curry, Deschutes, Harney, Hood River, Jefferson, Lake, Lincoln, Gilliam, Morrow, Sherman, and Wheeler.

dental care for adults. The level of unmet need was considerable. Expectations of dental access had been created but could not be fulfilled within the existing capacity and resources.

This section discusses the types of problems that were encountered, the initiatives undertaken to improve access, and the recommendations being considered to eliminate ongoing barriers. Oregon's experience is unusual in that the State expanded eligibility at the same time it expanded benefits, *and* at the same time it changed the delivery system. The convergence of these three factors presented numerous challenges to the State.

8.4.2 The Benefit Structure

A key concern about the dental benefit under OHP is that essentially all dental procedures were covered under the priority list based on their rankings above the cut-off line. There are no limits on the number or frequency of visits. As a result, dentists feel there is no prioritization in reality, and hence, no way to control the pent-up demand. Moreover, because some OHP eligibles are enrolled for a short period of time, they want the dental work to be performed as soon as possible. Most private practice dentists see patients every six months or annually, and thus, scheduling large numbers of patients for immediate work is challenging.

Dentists also do not feel they are in a position to limit services to patients. An administrative rule states that they cannot offer different care to OHP members. The question they ask is, should the goal be to provide "total care" or "basic care" to OHP enrollees?

The Oregon Dental Association (ODA) feels the State has been too generous in its coverage of dental care. Moreover, ODA feels there has been little accountability for how the dental capitation has been spent by health plans. ODA recommended that dental benefits be separated from medical benefits and that dental benefits be restructured to:

- Eliminate coverage for some services (but keep emergency and preventive care);
- Place more emphasis on public health interventions, especially fluoridation of community water supplies;
- Increase dental fees to stimulate dental capacity; and
- Impose an annual maximum as is done in commercial plans.

Dentists affiliated with OHSU and public dental clinics feel the capitation rate is adequate and maintain that the State needs more input from public sector dentists to counterbalance the concerns of private dentists. Instead of annual limits on dental care, they would rather see copayments based on a sliding fee scale. A copayment would limit utilization and slow demand, while still allowing urgent care to be done. While most private practice dentists think a copayment would be desirable to foster the appropriate incentives, they do no think it is worth introducing because the administrative costs of collecting would be too high.

8.4.3 State Initiatives

The State has been approaching the shortage of dental capacity from a number of perspectives. First, the dental capitation rate was raised by 40 percent in an effort to stimulate participation by additional providers. Only one plan, ODS Dental Plan, passed the

rate increase onto dentists in the form of higher dental fees. Then, ODS Dental Plan reportedly cut dental reimbursements twice, first by 8 percent and then by another 12 percent. Thus, even with the 40 percent increase in the capitation rate to health plans, individual fees to dentists are no better than before the rate increase. Other plans have not passed the rate increase on to providers because pent-up demand is so great.

The State has undertaken client education as a mechanism to improve dentist retention. Dentists expressed concern about the level of no-shows and demands for immediate appointments. Private dentists point out that most OHP clients have never had access to dental care and do not realize that a three-month wait for routine care is not uncommon.

The State has worked with existing dental care organizations and prepaid health plans to expand dental capacity and has helped to develop new plans and new dental clinics. Additionally, the State "uncoupled" dental coverage from the prepaid health plans and provided dental coverage exclusively through capitated Dental Care Organizations (DCOs). The State issued a new request for applications (RFAs) and attracted new plans and new providers. DCO enrollment now exceeds prepaid health plan enrollment as a result of the expansion of dental capacity.

The State also worked with four DCOs to establish an Exceptional Needs Dental Services (ENDS), to provide mobile dental services to those who can not obtain care in dental offices. Among those who may qualify for ENDS are residents of nursing homes and individuals with developmental disabilities.

For all the problems of inadequate access under managed care, there is widespread agreement that fee-for-service access is even worse. The State was sued by Oregon Legal Services for the lack of dental access under fee-for-service. OMAP agreed to continue the SafeNet hotline which provides information and referral for emergency dental services, as well as to notify clients of the availability of SafeNet every six months.

8.4.4 Strategies for Improving Access

Despite these initiatives, the State, health plans, and dental providers generally acknowledge that OHP has created expectations that could not have been fulfilled due to a chronic shortage of dental providers and substantial unmet need. As a result, the OHP dental benefit was modified to ensure the fiscal viability of the program, to improve provider participation, and to satisfy the basic level of unmet need.

The health plans and organized dentistry both oppose the open-ended nature of the dental benefit. Thus, the only form of "rationing" that takes place is through appointment waits. Private practice dentists believe that OHP members have unreasonable expectations about how many services they are entitled to and how quickly the services should be made available. And then, the dentists note, many OHP enrollees do not practice good preventive care, so all of the restorative work is for naught. They feel that if people pay for something, they take better care of it.

The State Task Force on Access to Oral Health Services (1995) recognized that even with improvements in preventive dental practices (e.g., fluoridation) and expanded capacity,

demand is still likely to exceed supply. The Task Force recommended, "to improve utilization, decrease costs and increase consumer responsibility, the Task Force suggests that OMAP consider incentives and limitations of coverage currently used in the private sector, e.g., copays for restorative work, emphasis on prevention and maximum annual limits for coverage, while being mindful of the economic and social status of many of the clients qualifying for such coverage."

The Health Services Commission issued recommendations, which were implemented January 1, 1997, to limit the dental benefit as follows:

- Limit routine exams and cleanings to one per year;
- Limit full-mouth X-rays to once every five years;
- Restrict partials to those with at least four teeth missing and who cannot chew;
- Limit relining of dentures to once every two years; and
- The crown to root canal ratio must be at least 50/50.

Dental care presents a concrete example of how the State has had to establish "guidelines" for the implementation of the priority list because of the open-ended nature of conditions and treatments included under the benefit package. The State is still considering the imposition of annual dollar limits and/or copayments for crowns, partials, and dentures. Adult dental care is an optional service under Medicaid; however, Oregon's waiver only provides for benefit changes to take place by moving the line upwards, rather than by

eliminating certain services that are out of sequence. In any event, all benefit changes must be approved by HCFA.

8.5 Spillover Effect of OHP on the Near-Poor Uninsured

A recent analysis of the uninsured in Oregon found that the uninsured rate had decreased from 17 percent in 1993 to 14 percent in 1994, and to 11 percent in 1996. The majority of those who remain uninsured are the "near poor," those between 100 and 200 percent of the Federal poverty level (OHPA, 1995; OHPA, 1997). About 23 percent of those with incomes between 101 and 150 percent FPL were uninsured, compared with 19 percent of those between 151 and 200 percent FPL, and only 7 percent of those over 200 percent FPL (OHPA, 1997).

There is widespread concern among advocates and providers that the near poor population has not shared in the gains experienced by the poverty population. For instance, some organizations have discontinued providing free care, assuming that OHP has addressed the needs of the low-income uninsured. In addition, the ability of safety-net providers to finance care for this population appears to be diminishing. This concern was expressed by the Federally-qualified health centers (FQHCs) in particular. However, local health departments also have faced financial constraints, and several have discontinued providing prenatal care to uninsured women due to lack of financial support; Hispanic women are likely to be hardest hit (Oregon Health Forum, 1996).

Although OHP is financing care that previously might have been uncompensated, the elimination of cost-based reimbursement for Federally-qualified health centers means that the FQHCs no longer have the resources to "cross-subsidize" care for those who remain uninsured. This is an example of how OHP may affect public and private providers differently. While private providers recognized an increase in fees relative to historical Medicaid rates and were pleased that charity care costs were declining, the FQHCs experienced reimbursement reductions (often on the order of 50 percent) and expressed concerns about the financial viability of continuing to care for those who remain uninsured. Both the Hood River FQHC and the Multnomah County Health Department report that the proportion of uninsured in their caseloads has remained fairly constant despite the implementation of OHP. OHP has brought about a shift of some Medicaid patients from public clinics to doctors' offices, but clinic slots are being taken up by those who remain uninsured.

Thus, a spillover effect of OHP in the short-run may have been to eliminate some health care resources for the low-income uninsured due to an impression that their need was eliminated. In the longer-run, however, safety net providers are concerned about their ability to serve this population if direct subsidies or opportunities for "cross-subsidization" are eliminated. OMAP noted that State and/or Federal governments need to deal with explicit funding decisions for these populations, instead of relying on cross-subsidies for uncompensated patients. In fact, the Oregon Legislature appears to be responding to the concerns about the ability of "safety-net providers" to serve the uninsured. Over $3 million

was allocated by the Legislative Emergency Board for safety net clinics in 1997. The State still needs to decide which providers are eligible to receive emergency funding.

8.6 Conclusion

By expanding eligibility and increasing provider participation, the Oregon Health Plan has improved access to care in the aggregate. This finding is clearly supported by the State's satisfaction survey, as well as the analysis of preventive care utilization before and after OHP was implemented.

The State has encountered challenges in meeting the dental care needs of the OHP population, in part because of longstanding shortages of dental providers more generally, as well as due to high levels of pent-up demand and a generous benefit package which until recently had few limits. The State has responded by issuing guidelines for dental care, establishing new dental care plans and new dental clinics, and providing mobile dental services for individuals with special dental needs.

The State also faced unanticipated challenges in the shift of pregnant women to managed care. Due to the OHP application process, women encountered delays in obtaining referrals to prenatal care. Referrals to maternity case management services dropped as a result of lack of health plan and provider familiarity with the services. The State has instituted administrative procedures to expedite the processing of applications for pregnant women. In addition, the State has eliminated the need for a referral to an OB provider (including certified nurse midwives). Both of these mechanisms should ensure more timely

initiation of prenatal care. The State also has instituted outreach and education services regarding maternity case management services, to alert both providers and beneficiaries about their availability.

The evaluation will continue to monitor access and satisfaction through such mechanisms as case study interviews, focus groups, telephone surveys, and encounter data analysis. In particular, through the telephone survey we will compare levels of access and satisfaction among low-income individuals enrolled in OHP versus those who are privately insured or who remain uninsured.

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Appendix A

Appendix A

Origins of the Priority List

The benefit package for the Oregon Health Plan (OHP) is based on a prioritized list of health services. The priority list was designed as a vehicle to allocate scarce resources. The State's intent was to set the cut-off line in accordance with available funding. The goal was to limit what services rather than which people would be covered under Medicaid. This appendix traces the origins of the priority list concept, discusses the information-gathering initiatives that the State undertook, and describes briefly the process used to develop the initial and revised priority list.

Community Roots

The formal roots of the Oregon Health Plan date back to the 1982 Health Coordinating Council, a policy advisory group for the Governor, chaired by Ralph Crawshaw.[1] At the time, Oregon was dealing with high unemployment and a depressed economy. An invited conference was held to evaluate the health needs of the medically indigent and issues of health resource allocation. The major question that the conference members struggled with was: how do people or how does society decide about the allocation of health care resources?

[1] The informal roots go back even farther to the mid-1970s, when Dr. Cranshaw and a group of ethicists, clinicians, and researchers met to discuss the allocation of scarce resources.

The Health Coordinating Council organized local meetings to discuss health care allocation with the lay public rather than relying exclusively on outside experts. Health systems agencies were used as the underlying networks for organizing approximately 500 meetings with 17,000 people (Oregon Health Decisions, 1985). A number of themes or values were identified during the community meetings. A parliament, unique in that community representatives worked with health policy-makers, took values language and translated it into policy language. Common themes were formulated into resolutions and were presented to the Oregon Legislature, ultimately forming the basis of the Oregon Basic Health Care Act (S.B. 27).

This issue of scarce resources played out in 1987 when the State legislature denied the allocation for most transplants.[2] Nine months later, the Emergency Board authorized the use of donated funds for coverage of transplants for Medicaid clients who met certain criteria. When the donations reached $85,000 in August 1988, they could be used to fund transplants. Twenty requests were received within one month, exceeding the available funds, and coverage was discontinued as of the end of September 1988 (by then, 30 requests had been received). Some of the requests were from non-Medicaid clients; some were from individuals not meeting the medical criteria. Of the 17 requests that were approved, 11 were eventually transplanted.

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[2] We are indebted to Lucy Lord-Lippincott at OMAP for reconstructing the history of transplants and their "catalytic role" in OHP.

One of the requests was from a boy named Coby Howard, who suffered from leukemia; he was denied coverage for an out-of-state bone marrow transplant based on the established medical criteria. This brought the issue of resource allocation to the forefront of public attention. A collision had occurred between public expectations and available resources. There simply were not enough resources to meet all needs.

Creation of the Health Services Commission

S.B. 27 mandated the creation of the Health Services Commission (HSC), which was charged with developing the list of paired conditions and treatments known as the Priority List. Its mandate[3] was to:

> report to the Governor a list of health services, including health care services of the aged, blind and disabled,... and including those mental health and chemical dependency services..., ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served.

The Commission was comprised of eleven members appointed by the Governor and confirmed by the Senate, including five physicians, a public health nurse, a social worker, and four consumers. HSC's five subcommittees[4] were instrumental in developing the priority list:

- The **Subcommittee on the Aged** was responsible for ensuring that the priority list reflects the special health care needs of the elderly. In

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[3] Oregon Revised Statutes, 414.720(2).

[4] In addition, an Ancillary Task Force was formed to address issues related to nutrition. Following the implementation of OHP, a Dental Subcommittee was established to develop guidelines for dental services (See Chapter 8).

addition, the subcommittee reviewed the conditions and treatments included in five "dysfunction lines" on the Priority List.

- The **Subcommittee on the Blind and Disabled** oversaw the priority list as it pertained to people with disabilities or who are blind.

- The **Mental Health Care and Chemical Dependency Subcommittee** was responsible for determining priorities for mental health and chemical dependency services.

- The **Health Outcomes Subcommittee** was responsible for maintaining the priority list and is the first line of review for coding changes, new information, and technical corrections.

- The **Social Values Subcommittee** was charged with ensuring that issues identified in the public outreach process were addressed.

Information-Gathering Initiatives

The Health Services Commission worked jointly with Oregon Health Decisions "to build consensus on the values to be used to guide health resource allocation decisions" (Hasnain and Garland, 1990). During early-1990, volunteer facilitators and coordinators held 47 community meetings with 1,048 local citizens throughout the State (usually 10 to 20 per county) to reflect on questions such as, "why are certain health care services important to us?" Thirteen value categories for which there was strong support were reported back to the HSC (See Exhibit A-1).

The Commission also held a series of 12 public hearings across the State. Grass roots organizations provided publicity and transportation to encourage participation by persons with disabilities, mental health consumers, and persons with low income. On the basis of that testimony, it was concluded that the general public wanted coverage for services

that might not be part of a traditional benefit package including dental care, prevention, mental health care, and chemical dependency services.

Exhibit A-1

Public Values in the Initial Prioritization of Health Services

Frequency of Discussion[1]	Value	Meaning
1	PREVENTION	Prevention includes the following -- a health care service which prevents illness (e.g., immunizations, prenatal care), detects symptoms at an early stage (e.g., mammograms, cholesterol and blood pressure screenings) or prevents a problem from degenerating to a more severe state (e.g., drug and alcohol treatment, insulin for diabetics).
1	QUALITY OF LIFE	Services which enhance Quality of Life are those which enhance a person's productivity and emotional well being, restore an individual's health, reduce pain and suffering, and allow one to function independently.
2	COST EFFECTIVENESS	Cost effectiveness includes looking at the cost of a treatment through a cost/benefit ratio. Services that cost little and produce positive outcomes in the long run, have a low cost/benefit ratio and are highly cost
3	ABILITY TO FUNCTION	Ability to function includes emotional well being, productivity (not necessarily economic), independence, and restore quality of life.
3	EQUITY	Equity was felt to stem from a basic premise that no person should be excluded from receiving health care when they need it. This was often voiced as feeling that government should take more responsibility in the health care arena to work towards the assurance that everyone has equal access to an adequate level of health care.

4	EFFECTIVENESS OF TREATMENT	Effectiveness of treatment includes an indication of success rate which incorporates a cure rate, improvement in quality of life, and length of success, with priority going to long term success over short term success.
5	BENEFITS MANY	A service which benefits larger numbers of the population compared to other services is one which "benefits many."

Exhibit A-1 (continued)

Public Values in the Initial Prioritization of Health Services

Frequency of Discussion[1]	Value	Meaning
5	MENTAL HEALTH AND CHEMICAL DEPENDENCY	Mental health and chemical dependency include education and awareness of alcohol and drugs, especially to populations such as pregnant women where impact on another life can be severely damaging. In addition, this includes services geared towards improving mental health and treatment for substance abusers.
5	PERSONAL CHOICE	Personal choice was thought generally to include autonomy and being an active participant in the decision making processes involved in one's own health care. In addition, personal choice meant having the right to choose the type of provider one goes to , whether traditional or nontraditional.
6	COMMUNITY COMPASSION	Community compassion includes a community concern for life, preserving the integrity of an individual and a family, and compassion for the vulnerable such as children and the elderly. Participants at the community meetings also referred to community compassion in the context of relieving pain and death with dignity (strong support for funding hospice care).
6	IMPACT ON SOCIETY	This value includes range of impact on society, i.e., positive to negative ratio, and consideration for societal needs and benefits.

6	LENGTH OF LIFE	Length of life includes treatments which extend life beyond what would otherwise occur without
6	PERSONAL RESPONSIBILITY	Personal responsibility includes encouraging individuals to knowledgeably take responsibility for their health, and often implies a responsibility to educate health care consumers.

[1] The frequency of discussion was as follows: 1=very high (all meetings); 2=high (more than ¾); 3=moderately high (¾); 4=medium high (more than ½); 5=medium (½); 6=medium low (less than ½).

SOURCE: Hasnain R and Garland M: *Health Care in Common: Report of the Oregon Health Decisions Community Meetings Process*. Portland, Oregon: Oregon Health Decisions, 1990.

The third initiative was a random telephone survey using the Kaplan quality of well-being scale. The purpose was to collect quality of life information represented by symptoms and functional impairment associated with an illness. Survey respondents were asked to value 23 symptoms and 6 functional impairment states.

The Initial Priority List

Data from the three initiatives -- community meetings, public hearings, and the telephone survey -- were presented to the Legislature, which instructed the HSC to develop a prioritized list of health services. For the purpose of the list, the HSC defined a health service as "an intervention expected to maintain and/or restore health or well being." The list was constructed by gathering together all the conditions by ICD-9 codes and treatments by CPT-4 codes. Next, HSC paired conditions with treatments into line items of condition-treatment (C-T) pairs.

Initial attempts at ranking the C-T pairs used only "cost-effectiveness" data, which led to counter-intuitive rankings. As a result, HSC categorized the C-T pairs into 17 groupings that relied on the values from the community meetings and their own

intuition. C-T pairs within the same category were then ranked on a net cost-benefit analysis from clinical outcome data provided by medical experts. Finally, the Commission did a line-by-line review and when it seemed appropriate, moved a pair up or down the list.

The Revised Priority List

The Federal Government rejected this list based on an assessment by the Department of Health and Human Services (DHHS) that the ranking methodology may have violated the Americans with Disabilities Act (ADA). DHHS felt that "quality of life" conveyed a negative meaning -- an implication that the life of a disabled person is presumed to be of lesser value. DHHS concluded that the methodology devalued health states with residual disabling symptoms. The State strenuously disagreed with the Federal decision, but nevertheless, submitted a revised plan to DHHS that no longer incorporated quality of life measurements of specific conditions. The State proposed to downrank treatments that left individuals in a "symptomatic state." Again, the plan was found in violation of ADA by "downranking treatment on the basis of residual symptomatic conditions." DHHS approved the revised plan but required Oregon to re-rank its priority list yet again, without taking into account "whether treatment returned an individual to an asymptomatic state" (Issues in Law and Medicine, 1994).

The Priority List consisted of 696 C-T pairs that were ranked in four steps: (1) by improvement in 5-year survival; (2) then by cost; (3) then by alphabetical order; and (4) finally, by hand-adjustments that took into consideration the community values. Five dysfunction lines were added to the C-T pairs for neuro-muscular and related conditions that do not have effective treatments but may be managed medically. The list was implemented on February 1, 1994, and funded through line 565. The incorporation of the

prioritized list of services into the Oregon Medicaid Reform Demonstration was the first time such a list had been used to define a benefit package.